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PROBLEMS ASSOCIATED WITH THE MEDICARE REIMBURSEMENT SYSTEM FOR HOSPITALS

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ORIGINAL

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

WASHINGTON, D.C.

MARCH 10, 1982

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PROBLEMS ASSOCIATED WITH THE MEDICARE REIMBURSEMENT SYSTEM FOR HOSPITALS

WEDNESDAY, MARCH 10, 1982

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 9:13 a.m., in room 3110, Dirksen Senate Office Building, Hon. John Heinz, chairman, presiding.

Present: Senators Heinz, Percy, Cohen, Pressler, and Melcher.

Also present: John C. Rother, staff director and chief counsel; E. Bentley Lipscomb, minority staff director; Bill Halamandaris, director of oversight; David Holton, chief investigator; Kate Clarke, communications director; Kathleen M. Deignan, minority professional staff member; Robin L. Kropf, chief clerk; Angela Thimis, staff assistant; and Eugene R. Cummings, printing assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Senator HEINZ. The special committee will come to order.

In April of last year, a 79-year-old woman walked into a small welfare hospital in Perris, Calif. She was happy and talkative, hugging the hospital attendants, who checked her into the facility. Two hours later, she was dead, 1 of 14 to die in that facility's 6-bed intensive care unit during a 6-week period last spring. Most of those who died were elderly; their average age was 77. Most of them were poor, on medicaid; all but one was on medicare.

A male nurse at the facility has been arrested and charged with killing 11 of the 14 who died. The inordinate number of deaths in such a short period of time led the California Health Department to request a temporary restraining order, suspending the facility, Community Hospital of the Valleys, from the medicaid program. The health department charged that the hospital had not hired appropriate and adequate personnel, failed to act in a timely and effective manner when a disproportionate number of patients died in a short period, rendered substandard care, and engaged in conduct inimical to the health and welfare of the hospital's patients.

[The temporary restraining order referred to follows:]

BEFORE THE STATE DEPARTMENT OF HEALTH SERVICES, STATE OF CALIFORNIA

In the Matter of the Accusation Against: Community Hospital of the Valleys, a California corporation, d.b.a. Community Hospital of the Valleys, 2224 Ruby Drive, Perris, Calif. 92370, Respondent

No. 1-0017—ORDER FOR TEMPORARY SUSPENSION PENDING HEARING

Upon reviewing the departmental reports relating to the care of patients at Community Hospital of the Valleys, a general acute care hospital operated by Community Hospital of the Valleys, a California corporation, pursuant to license No. 330692172, as delegate of the Director of the California State Department of Health Services, I find that: (1) Physicians have been granted staff privileges without an appropriate review being made of all references set forth in their applications; (2) chiefs of services have signed approvals for their own privileges; (3) the medical staff has failed to meet to review and analyze their clinical experience and competence; (4) the medical staff has failed to participate in a continuing program of professional education based on a retrospective evaluation of medical care rendered; (5) respondent has failed to act in a timely and effective manner when a disproportionate number of patients died in a short period of time; (6) the medical staff has no effective means of reviewing patient deaths; (7) appropriate and adequate numbers of personnel have not been provided, including nursing personnel in numerous departments and units throughout the hospital, medical records personnel, diatetic personnel and administrative personnel; (8) a committee of the medical staff has failed to determine appropriate procedures to be followed in the operating room; (9) the nursing service has not received continuing education and training; (10) all appropriate personnel have not attended various committee meetings; (11) outdated and possibly contaminated items have been available for use in the operating room; (12) policies and procedures of various committees have not been properly maintained; (13) the consulting pathologist has not consulted at suitable intervals; (14) the pharmaceutical service has not been properly operated and monitored; (15) appropriate reference materials, including infection control guidelines, have not been available; (16) medical gas cylinders and systems have not been maintained in a safe and appropriate manner; (17) respondent has engaged in conduct inimical to the health and welfare of the hospital's patients, which patients include Medi-Cal beneficiaries; and (18) respondent has rendered substandard care to Medi-Cal beneficiary patients. Based on the above, I find that it is necessary in order to protect the public welfare, the patients' welfare, and the interests of the Medi-Cal program, to issue this temporary suspension order prior to hearing pursuant to Health and Safety Code section 1296 and Welfare and Institutions Code section 14123(b).

Respondent's license to operate Community Hospital of the Valleys is hereby suspended. The effective date of suspension is the 13th day of May, 1981.

Pursuant to Health and Safety Code section 1296 the Director shall hold a hearing within 30 days after receipt of a notice of defense from respondent. This suspension shall remain in effect through the holding of a hearing on the attached Accusation, and until such time as the State Department of Health Services has made a final determination of the merits, or for 60 days after the hearing is completed, whichever is shorter.

Dated: May 12, 1981.

RICHARD H. KOPPES,
Chief Counsel,
Office of Legal Services.

Senator HEINZ. It has been reported that hospital officials have been hostile and failed to cooperate with investigators, characterizing the deaths as simply "a statistical error."

Today, the committee will hear from the controller of the State of California, who will describe an audit and investigation of that facility. The controller has found that the hospital, now in bankruptcy, was not much more than a paper shell, incorporated to contract and subcontract with other companies controlled by the same people. The controller has found an intricate and integrated corporate structure designed to pyramid costs and to funnel State and Federal funds to a family of related parties, separate legal entities, so organized as to effectively preclude the recovery of the improper charges identified.

The controller has found, as this committee has found in more than 10 years of investigating abuses in medicare and medicaid, how frequently patient abuse follows financial manipulation; in other words, how the incentives of maximizing reimbursement too often led to poor care, neglect, or worse.

There is a profound and bitter irony in knowing that at least some of those who died in Perris, Calif., died because they were poor, because they were old, because they had no choice, because the entrepreneurs who controlled the facility were too busy milking medicare to care about the people they were supposed to serve.

The purpose of the medicare program was to provide quality health care for the aged. The preamble to that important legislation declared that good health was the right of all Americans, and that there was to be no discrimination as far as access to health care, based on ability to pay.

Since then, we have seen costs escalate, abuse increase, until some suggest that the Federal Government must break its covenant with the poor and aged and shift the burden of caring. Others seek a quick fix through tinkering with the program and more regulation. Witnesses will testify to the difficulty of administering, controlling, and providing service under the current reimbursement system. In fact, it seems that if Congress had set out to design a payment system guaranteed to skyrocket costs and confuse honest providers with countless complicated regulations, inviting abuse, it is hard to imagine how Congress could have succeeded better.

All of these things force the same conclusion. It is way past time we reexamine the way we pay for services under medicare—that is to say, the retrospective, cost-based reimbursement system; the incentives that system creates, and the consequences to the patient and the taxpayers. It is time we begin a very careful consideration, but a rapid consideration, of the alternatives. It is time we find a way to provide the incentives that will maximize service instead of maximizing reimbursement. It is really time we restate our commitment to the poor and the elderly and find a better way.

That completes my opening statement. I assume there are some others.

Senator Cohen, I assume you were here at an early hour.

STATEMENT BY SENATOR WILLIAM S. COHEN

Senator COHEN. Thank you, Mr. Chairman. I have a couple of observations. Last year, Americans paid more for health care than any other previous year, and the average health care expenditure was five times greater the amount that we paid for the same services 15 years ago.

The Federal Government's involvement in health care, I think, is growing at a correspondingly alarming rate. Medicare and medicaid accounted for over two-thirds of all public spending for personal health care last year, an amount equal to over 9 percent of the gross national product.

The cost of hospital care led advances in medical costs. Federal expenditures to hospitals totaled nearly $44 billion in 1980, including $30 billion under medicare and $14 billion under medicaid. Hospital costs increased at the rate of 17 percent in 1980 and 18 percent in 1981.

The rapid escalation in health care costs, I think, can be attributed to many factors. But health care experts generally agree that the absence of incentives to hold down health care costs has been the primary factor driving up health care spending. Unless we find ways to strengthen market forces and competition in the health care industry, we are not likely to succeed in our efforts to hold down health care spending.

As Senator Heinz has indicated, the reasonable cost reimbursement system adopted by the Federal Government for medicare, which has been widely copied by insurers and the States under medicaid, has not only insulated providers from the effects of competition, but has also provided perverse economic incentives.

Last year, in a hearing before the Permanent Subcommittee on Investigations of the Governmental Affairs Committee, we heard testimony that revealed rampant abuse in the $1 billion a year home health care program. And, Mr. Chairman, we filed a report, which I believe the staff has looked at, describing remarkable similarities to the kind of abuse that took place in the home health care industry, the kind of shell corporations that were set up, not-for-profit agencies, which were simply a ruse which resulted in millions of dollars of taxpayers' dollars being wasted, without any benefit going to the people who are supposed to be served.

In another hearing, before this committee, we heard how a doctor ripped off medicare, social security disability, and other Federal programs for hundreds of millions of dollars. And I am happy to point out, Mr. Chairman, that Dr. Kones, who testified before the committee, recently received the harshest sentence ever from the New York court, some 7 years, plus a $300,000 fine, on top of restitution of $500,000 that he stole from the Government. I think part of that sentence was attributed to the kind of testimony that was presented before this committee.

Today, we will hear a report on 30 Illinois hospitals,[1] which found substantial inadequacies in both reimbursement policies and auditing procedures. Errors in every single hospital reviewed resulted from confusion over Government policy and related auditing problems. We will also learn about the work of the New York Fraud Control Unit, which resulted in 100 hospital fraud indictments.

Additionally, California investigators have uncovered abuses in medicare in every single level of management involving conflict of interest cases with contractors. The end result of these investigations is ultimately poor patient care, patient abuse, and sometimes, as Chairman Heinz has suggested, even death. Poor management, systematic abuses, and lack of cost controls can only result in inadequate service for needy patients.

For the elderly, who pay over 40 percent of their own health care costs, and who seek the services of hospitals more than any other age group, we must not allow these abuses to continue unabated. An older person, who is now paying more for medicare services than ever before, lives in fear every day that a catastrophic illness will mean financial ruin. The threat of having to pay even more for their medical services because the Government might cut back on medicare is equally frightening.

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[1] Hospital audit project conducted in the State of Illinois by: Department of Health and Human Services, Office of the Inspector General; Health Care Financing Administration, Division of Quality Control, Chicago Regional Office; Illinois Department of Public Aid, Bureau of Program Integrity; November 1981.

Mr. Chairman, we owe it to not only the taxpayers, but the elderly in this country, to see that we spend our health care dollars wisely.

Intermediaries, who have invested time and effort to audit health care provider costs, have found a return of $26 for every single dollar spent. I hope we can hear what kind of efforts are being undertaken by the Inspector General's Office to find out the same kinds of savings we could make for the Federal Government.

Senator HEINZ. Senator Cohen, thank you very much.

Under our "early bird" rule, I understand Senator Pressler was here, and then Senator Melcher.

Senator Pressler.

STATEMENT BY SENATOR LARRY PRESSLER

Senator PRESSLER. Thank you very much.

I have to go to an executive meeting of the Commerce Committee, but I appreciate this opportunity to say a few words.

First of all, let me say that I come from a State, the State of South Dakota, where I do not believe that we have had any fraud in medicare reimbursement to hospitals. Nevertheless, where it does exist, it should be investigated and corrected.

Indeed, the fact that there are some areas of fraud, waste, and abuse, make it more expensive for everybody and make the program less credible. In my State, we have many 30-bed hospitals, and our people are very careful, and we have had no reports of widespread abuse. Nevertheless, if abuse does exist, it makes the costs in those 30-bed hospitals greater, and it makes the total costs of medicare greater. It also discredits the program.

In the nursing homes in my State, the patients there who might be on medicare—of course, that would not be under the terms of this particular hearing—but I have found in my listening in meetings, and in senior citizens' seminars, that there is a great deal of care taken and a great deal of pride in the honesty practiced in respect to medicare reimbursements and medicare payments. On our Indian reservations in my State, I am told that there is not direct medicare reimbursement usually to the hospitals, that it is a public health function.

So what I am saying here is that I think all of us should be concerned about this, even if we do not have a problem in our immediate community, because it is causing the total program to be discredited, a program which is very good and which serves many Americans well.

In 1980, medicare contributed $30 billion to hospital revenues in this country. Hospital costs increased by 18 percent in 1981, and can be expected to increase again in 1982. The percentage of those over 60 in our population increases each year, and this, too, will contribute to greater medicare expenditures.

Nearly everyone agrees that hospital costs are grossly inflated, and that we have the third-party payor system to thank for it.

President Reagan has made hospital cost containment one of his goals, and the logical place to begin that task is with the Government-funded health care programs like medicare. Let us not begin, however, by simply lowering reimbursement levels, across the board, or by increasing the deductible cost borne by individuals. These measures penalize those whom this program was designed to serve.

The system for determining "reasonable cost," on which medicare reimbursement is based, is a system that has frustrated providers and payors alike. The audits built into the system are not sufficient, for the most part, to uncover major fraud. Hospitals complain that the system does not allow them to bill for all the costs involved in care and treatment, and so they must engage in cost-shifting. Meanwhile, the cost of a day's stay in the hospital goes up and up, at the rate of 620 percent over the last 15 years.

Studies show that the money spent by medicare on audits usually saves the Government more than was spent on the audit. Yet testimony that we will hear this morning will show that this is only the tip of the iceberg.

If the Health Care Financing Administration was equipped to perform thorough investigative audits, we might very well be able to eliminate a significant amount of abuse of the system, thus saving medicare money for those who need it most, not the hospitals, but our older Americans, who suffer from a variety of chronic illnesses.

If we really wish to eliminate waste and abuse in Government spending programs, this is one place to start. I do not wish to imply that all hospitals receiving medicare funds are engaged in fraudulent activities. I do wish to express my belief, however, that we should step up our efforts to identify those who are perpetrating fraud, so that medicare dollars can be spent as originally intended—providing health care for those older citizens who live on fixed incomes and have the right to expect their Government to help them obtain adequate medical care.

Mr. Chairman, I commend you for calling these hearings.

Senator HEINZ. Thank you, Senator Pressler.

Senator Melcher.

STATEMENT BY SENATOR JOHN MELCHER

Senator MELCHER. Thank you, Mr. Chairman.

There is no question that these hearings are very timely and should prove very useful, because who is going to argue—none of us, I am sure—that if you can cut the cost of the overhead or if you can make the delivery system of health care more direct—I am sure the dollars that are spent on Medicare or health care have not only done a lot of good for the elderly, but have done a lot of good for the Government itself.

But the question is, what is this rationale; what is the plan, if we are going to reduce administrative expenses. How do we do it?

I think everybody wants to know. It is not all that simple.

I have heard a lot of complaints over the last several years that the paperwork required for medicare is really hampering—treating the elderly sick. It starts at the doctor's office. There are a lot of times I have been told by physicians, that they have to have a special person just to handle that paperwork. I do not know whether that saves anybody any money.

If we are going to strike a balance here, where we have a reasonable amount of paperwork to get the job done, let us see what that scenario is, that rationale, that plan—whatever term we want to use for it—because our goals are all the same: Let us treat the sick. When you get to the hospital, small hospitals tell me that they are actually bogged down, not only by the regulations that are imposed on them because of medicare, but by extra expenses.

Now, we all admit—I mean, Congress admits, this committee admits, and every Senator admits that looks at this, and every House Member admits that has looked at this—that there must be better ways of providing honesty, providing a real check on whether these dollars are properly spent, and are not somehow blown off as sort of a little gimmick for extra reimbursement. There ought to be some way of doing that without bogging it down in too much additional costs just to follow and comply.

The smaller hospitals in particular—and I happen to be very sensitive to that, because most of our hospitals in Montana are classified as smaller hospitals—are told to do this and do that by regulations put out so they can participate in medicare. They see some sense in some of them; in others, they do not see any sense at all, but they must comply, causing additional expense to the hospital, which must be borne by medicare, or the patients, or both.

So, Mr. Chairman, let us hope that what we are going to see here presented today in the testimony is not a question of simply more regulations to make sure it is honest, but a simpler procedure of regulations that lead to less paperwork, that demonstrate that the dollars we are spending on medicare are really going for health. That is the primary goal, and if we can do that more efficiently, we want to do it, but I think to do it more efficiently and put more of the dollars of medicare into treating the ill and treating the elderly who are ill and who must be hospitalized, that we are going to have to see a reduction in some of this paperwork.

Thank you very much.

Senator **Heinz**. Senator Melcher, thank you.

In addition to agreeing with my colleagues, I would just observe that one of the reasons for this hearing is not only because of the timeliness of the information that will be revealed here, which is very current and new information. It also comes at a very propitious time. The Department of Health and Human Services will, within the next several weeks, be making a number of decisions and recommendations on the reform of the so-called reasonable cost-based retrospective reimbursement system that we use for medicare. They will be attempting to decide on a number of prospective reimbursement mechanisms. It is very, very important that the committees of Congress give them every reason to move ahead as rapidly as possible. The idea of prospective reimbursement has been around for a long time. Indeed, this administration has been around for a reasonably long time—16 months at the end of April—and there is a great deal that needs to be done.

Finally, the Chair would observe that, according to my own estimates, if we just did a better job of trying to recover the cost that we now lose in this program through more or less classic waste, fraud, and abuse, you are talking about $4 billion in a roughly $50 billion medicare program, $4 billion that could be recaptured just by better procedures. And that does not take into account the incentives in the program from cost-shifting, for overbilling to the program, in a perfectly, so-called honest way.

The system, I am coming to be convinced, makes bad guys out of good guys. It is like all the people in this country who do not declare all of their income. They are not necessarily bad people, but they are doing something wrong—like all the people who take one additional deduction on their income tax form, just because they think they might be able to do it. That does not make them evil, but it is still not right.

This system, just like the two I described, encourages accountants in hospitals to go, if you will, that extra step, that extra mile, to maximize their reimbursement. The system invites it, and it is, to my mind, a system, therefore, that we must find a way to change.

Our first witness today is Tom Moore, special assistant to the California State controller.

STATEMENT OF THOMAS G. MOORE, JR., SACRAMENTO, CALIF., CONSULTANT TO THE CONTROLLER, STATE OF CALIFORNIA, ACCOMPANIED BY STEVE KOVASIK, CHIEF DEPUTY CONTROLLER

Mr. MOORE. Good morning, Senator Heinz.

Senator HEINZ. Good morning, Mr. Moore. Please proceed.

Mr. MOORE. Thank you.

Mr. Chairman and committee members, I am Tom Moore, special assistant to State Controller Ken Cory, and with me is Steve Kovasik, who is the chief deputy in the office of the State controller in California.

We bring you Mr. Cory's regrets that a flu bug has kept him at home, and he could not be here himself, because he has taken a great interest in this subject, and has pioneered the use of the controller's authority in California to evaluate the use of public funds for health and other services. He looks forward to the outcome of your inquiry, in the hope that we will get some fundamental reforms in the medicare reimbursement system.

If it is appropriate—I am not sure this has been done—I would like to submit to the committee the audit report prepared by the controller's office with the inspector general, for the record.

Senator HEINZ. Without objection.[1]

Mr. MOORE. Thank you. Copies have been provided to the committee staff.

My testimony, which is Mr. Cory's testimony, was a summary of the report, and in the interest of your time, I am going to summarize my summary.

Senator HEINZ. Before you go any further, Mr. Moore, I understand that—taking nothing away from Mr. Cory, who is your supervisor—but that you may be even somewhat more familiar with the details of this situation than Mr. Cory, because I understand you did a good deal of the work on it yourself. Is that correct?

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[1] See appendix, page 83.

Mr. MOORE. I have been involved with it, yes, that is correct.

Senator HEINZ. Before you get any further along in your remarks, I think that this is the appropriate place to insert the prepared statement of Mr. Cory. So, without objection, so ordered.

[The prepared statement of Mr. Cory follows:]

PREPARED STATEMENT OF KENNETH CORY

Mr. Chairman, my name is Ken Cory. I am the controller for the State of California. I appreciate the interest of this committee in the problems of hospital organization and management and their relationship to medical care costs. I am especially grateful for this opportunity to report to you the results of our audit of the Community Hospital of the Valleys.

Under the California constitution, I am responsible as controller, for assuring the taxpaying public that their funds are spent for the purposes intended by the legislature and in amounts supported by appropriate documentation. Until I became controller, the practice was to accept the certifications of State agency administrators that bills were payable as submitted, with limited claims review. As our California budget has grown—now exceeding $23 billion annually—I have broadened our claims review and audit responsibilities to include evaluation of program effectiveness, especially where large sums of State and Federal dollars are involved.

As we are all painfully aware, large sums of dollars are involved in the cost of medical care. California's Medi-Cal budget will exceed $5.5 billion next year, more than the entire public and private health care expenditures in the State only 10 years ago. While other aspects of our economy are slowing down, health care inflation is unabated, rising nearly 1 percent in February, as if the economy of the health industry were unrelated to the purchasing power and economic strength of the community as a whole.

In many ways, the medical-industrial complex is well insulated from the ills of the economy, protected mainly by third-party payers locked into a reimbursement system that virtually assures meeting industry financial goals. Ultimately, of course, physicians and hospitals will suffer collection problems as the numbers of unemployed grow and fewer patients are insured, but meanwhile, they enjoy the happy prospect of being among the first to be paid, even when funds are short. For these and other reasons, I welcomed the opportunity offered by the Inspector General's willingness to provide resources for a review of hospital structure and its impact on costs.

Because hospitals account for nearly half the Nation's medical costs, every element of organization or performance that affects costs deserves examination. We cannot afford to assume that present hospital organizations are the most cost-effective or that the rapid changes now occurring in hospital financing and management structures will necessarily benefit the public.

To the contrary, we have good reason to suspect that certain corporate arrangements tend to increase charges, if not costs, and the audit I am submitting to you today was undertaken to test that premise. The result of our investigation confirms our worst suspicions; not only do certain corporate arrangements aggravate costs, the reimbursement system used by medicare and medicaid encourages the development of those corporate structures.

You should know that the selection of the Community Hospital of the Valleys as our audit site followed a procedure designed to screen out those hospitals in California most dependent on contract arrangements for basic services and whose costs were significantly above State averages. From data available on 555 hospitals, 72 screened out as good candidates for review. Of those, Community Hospital of the Valleys was the best, meeting most of the criteria.

Using information from the Medi-Cal program plus our own investigative audit of the corporate activities at the hospital, including available information about the corporations providing most of the contract services, this is what we found:

- —A series of related corporate structures, owned or controlled by a small group of individuals, controlled most of the cash flowing to and through the hospital.
- —Prices for basic services were far higher than those of the industry as a whole in California.
- —Comparative shopping and competitive bidding were not used by the hospital to control costs.

—Management inefficiences and irregularities inflated costs; as examples, note the excessive fees paid for malpractice insurance and the use of the Royal Burbank Air Force as a messenger service.

—The policymaking machinery of the hospital was so weak that an unauthorized loan was made to another hospital by the contract administrator. The loan went undetected for some time.

—Contracts with the related organizations providing services to the hospital were written so that they were insulated from reductions in reimbursement that followed Medi-Cal audits. This was a major cause of the hospital's bankruptcy.

—The major subcontractor, Perris Valley Scientific, Ltd., overcharged the hospital and when the PVS contract was to be terminated, the new administrator was offerd a financial interest in PVS. Efforts were made to keep the offer a secret to avoid violation of the related organization regulations.

—Minutes of meetings were altered to conceal the related character of contractors to the hospital.

There is good reason to believe that the hospital organization and its relations with contractors were designed mainly for the purpose of artificially inflating costs, and therefore charges, while at the same time opening the cash flow at several points to a few people.

The goal, of course, was profits. The rewards to health professionals that come with providing health services to those in need are lost in financial arrangements that reward higher and higher costs. Investors have no incentives to construct lean, cost-effective arrangements. The more money flowing through the system, the greater the opportunity to make and conceal profits. Because our reimbursement system virtually eliminates risk and pays on a cost and charge basis, we encourage the proliferation of costly equipment, services, and corporate structures that make the most of them.

Nothing in the record of decisions supporting the corporate structure of the hospital suggests that the arrangements were undertaken to improve efficiencies of patient care.

Clearly, the arrangements violate the intent and letter of the rules prohibiting self-dealing, yet Government enforcement is slow, expensive, and heavy with procedural difficulties.

Unfortunately, self-dealing is commonplace in the health industry.

Nursing homes in California engage in self-dealing contracts on a massive scale. According to a recent report of the California Health Facilities Commission, 707 of 1,130 long-term care facilities reported dealings with related organizations. That same report disclosed that profits on equity in 1978 averaged 41 percent on nursing homes although Federal and State laws limit or try to limit ROE to 12.23 percent. The report does not discuss profits from related organizations because these data are not collected. My guess is that the profits there would be as high or higher.

Investors in a hemodialysis facility in Marin County were found in 1979 to be earning 361 percent return on equity through self-dealing arrangements, although the front corporation receiving payments from medicare filed statements showing a loss each year.

Prepaid health plans have been shown repeatedly to have increased costs and profits through self-dealing arrangements. Senate investigations of California prepaid scandals a few years ago led to reforms in Federal policy toward contracting with prepaid plans, but last year's Reconciliation Act swept most of those reforms aside.

Our screening of hospitals for this audit showed that another 71 deserve close scrutiny using the criteria of high cost and dependence upon contracts for services. That is more than 10 percent of the hospitals in California.

Everyone except the investors suffer from these arrangements. Even with their limitations, our State and Federal audit activities are far more complete and aggressive than those in private insurance and service plans which typically are little more than passthrough arrangements, only superficially examining costs if at all, leaving private patients virtually unprotected. While there is no way to estimate the extent to which corporate arrangements artificially inflate costs, there is no doubt that the overall impact is enormous when we see such profits as in the examples mentioned above.

As the biggest buyer of health care, Government cannot tolerate being manipulated in this way. We must step up auditing and monitoring so that our law enforcement agencies can move quickly. Delays make cynics of those who evade the law.

We need stronger laws compelling wider disclosure of all financial transactions of organizations doing business with hospitals, so that basic information about where the money goes can be obtained on a timely basis. Hospitals are sufficiently vested with a public interest that public access to information should not be restrained.

Federal and State limits on equity earnings should be applied to contractors and major subcontractors and direct fiscal recovery from contractors should be possible where they are shown to be related entities and the hospital itself cannot make restitution. I suggest that penalties should be assessed where disclosure is not prompt, accurate, and complete, and that reimbursement should be withheld where profits have been made in excess of those allowed.

If competitive bidding and comparative shopping were required, the result of all these steps would be a sharp reduction in the rewards and a considerable increase in the penalties for deliberate inflation of costs through improper management and self-dealing.

But in the long run, the costs of enforcement will become a steadily larger share of our health bill unless the basic incentives in the system are changed.

George Bernard Shaw once commented, that our willingness to pay surgeons more to cut off legs than to save them, made him despair of political humanity. Economists who disagree on nearly everything else have joined a growing chorus of criticism of the way we pay for health care. Not only are the incentives wrong and the rewards backwards, the results are doubtful. Our reimbursement system guarantees that costs will go up, that devious corporate arrangements will proliferate to hide profits, that the medical-industrial complex will consume a steadily increasing share of our resources, and that health providers will continue to be rewarded not so much for preventing and maintaining health, but for the most radical and aggressive treatment of illness. It is ironic that this largest of our nonmilitary enterprises should be conducted without negotiation with those who provide the services, without full and candid disclosure as to costs and quality, and without requirements as to outcome. We pay for nothing else in our society with as little demand for performance as we pay for health care.

You at the Federal level, and we in the States, must face the political reality that our health financing machinery is obsolete and is working mainly to reward the providers without guarantees that the public will have access to affordable, appropriate care. I share your frustration at the complexity of the task of reform, especially now that such large interests are vested in maintaining the status quo. But we know that we cannot afford to continue the present inflationary practices. I hope this audit report will help light the way toward finding solutions, recognizing that far from an isolated example, it is symptomatic of an illness within an industry that cannot, or at least will not, cure itself.

Thank you.

Senator **Heinz**. Please proceed, Mr. Moore.

Mr. **Moore**. Thank you.

This audit was undertaken to test a premise which is widely held, that certain kinds of financial and corporate arrangements in health delivery systems contribute to inflating costs and sometimes conceal, or at least obscure, the flow of profits through health delivery organizations. The premise has a long historical background. California investigations since the beginning of the Medi-Cal program in the midsixties have found that complex organizational structures frequently contribute to concealing profits, from nursing homes through hemodialysis programs to hospitals and through prepaid health plans.

In the case of the Community Hospital of the Valleys, the data from over 500 hospitals in California were sifted, looking for hospitals that had two overriding characteristics. One was their high cost per units of service, and the other, their dependency upon contractors for the provision of basic and ancillary services in the hospital. Of the 555 hospitals whose data were reviewed, 72 were shown to have a significantly higher cost component and dependency on contracting in the State, and of those, the Community Hospital of the Valleys seemed the best audit site, because it met most of the criteria.

The audit was undertaken; contract staff brought into the controller's office, and with the assistance of Medi-Cal audit review teams, who had already been concerned about the hospital's financial condition and its building practices——

Senator HEINZ. May I clarify something that you are saying?

Mr. MOORE. Yes.

Senator HEINZ. You, in effect, used a screen through which 72 hospitals were caught in, and you just picked this one out because it seemed the most obvious place to start.

Mr. MOORE. That is right.

Senator HEINZ. You did not know at that time of their problems with the California Health Department. Is that correct?

Mr. MOORE. That is right. We did not know about the patient death issue at all. It was a completely random coincidence.

Senator HEINZ. So, yours was a completely separate investigation that just happened coincidentally to take place?

Mr. MOORE. That is right. We did know that they had problems with quality of care, but we did not know about the patient deaths, at the time.

When the screening was done and the audit investigation began, the basic findings, which are summarized in the testimony, were roughly as follows:

A series of related corporations, owned or controlled by a single small group of individuals, controlled most of the cash flowing to and through the hospital.

Prices for basic services were far higher than those of the industry as a whole in California.

Comparative shopping and competitive bidding were not used by the hospital to control costs.

Management inefficiences and irregularities inflated costs. For example, there were excessive fees paid for malpractice insurance, and there was the use of something called the Royal Burbank Air Force to carry checks and bills back and forth between the hospital and downtown Los Angeles.

The policymaking machinery of the hospital was so weak that an unauthorized loan was made to another hospital by the contract administrator.

Contracts with the related organizations providing services were written so that they were insulated from reductions in reimbursements, which was a major cause of the hospital's bankruptcy. The major subcontractor overcharged the hospital, and when the contract with that group was to be terminated, the new administrator was offered a financial interest in the new contractor. Efforts were made to keep the offer a secret to avoid violation of the related organization regulations. Minutes of meetings were altered to conceal the related character of contractors to the hospital.

Those are just the high points of what was learned through several months of investigative auditing. Yet, from our point of view, there is every reason to believe that the hospital organization and its relations with contractors were designed mainly for the purpose of artificially inflating costs and therefore, charges, while at the same time opening the cash flow at several points to a few people. The goal, of course, was profits. The rewards in these arrangements can be considerable, because investors have no incentives to construct cost-efficient organizations in a cost-based reimbursement system.

As you pointed out in your opening remarks, Mr. Chairman, our reimbursement system virtually eliminates risk by paying on a cost-and-charge basis and encourages the proliferation of costly equipment, services, and corporate structures to make the most of them.

This is not a unique situation. To cite just three examples from California:

Self-dealing arrangements have become commonplace in the health industry. Nursing homes, for example, according to a recent report of the California Health Facilities Commission, are engaging in self-dealing contractual arrangements on a massive scale. According to a report, 707 of 1,130 reporting long-term care facilities reported dealings with related organizations—707 out of 1,130. That same report disclosed that profits on equity in 1978, which is the last year for which complete data have been examined, averaged 41 percent on nursing homes, although Federal and State laws limit, or try to limit, return on equity to 12.33 percent. The report does not discuss profits from related organizations because we did not have those data. My guess is that the profits would be even higher if the related corporations' books could have been examined.

In a hemodialysis facility in Marin County—keep in mind that hemodialysis is paid for by medicare—we found from examining the financial condition of related organizations, a profit return on equity of 361 percent in a 1-year period, in an organization which, in its statements to the medicare administration in San Francisco, had been losing money. At the time that we examined the books, we were concerned that they might go out of business because of the losses in the basic corporation.

Prepaid health plans, as this Senate has repeatedly demonstrated through investigations, have been organized to increase profits by self-dealing arrangements, not only in California but throughout the country.

As I pointed out earlier, our screening for this project showed that another 71 hospitals deserve very close scrutiny if we apply the same criteria. That is more than 10 percent of the hospitals in California.

I would conclude my summary with these observations. We can step up enforcement procedures, and we must. We have got to increase our audit and monitoring capabilities. We need stiffer requirements for disclosure, for full and candid, open revelation of the books, and the financial relationships, the corporate structures, so that we can tell exactly where the money goes.

In the long run, I fear that enforcement by after-the-fact checking of the books is going to be an increasingly costly element in the health care system and probably unnecessary if, as you pointed out, we begin to reexamine and reconstruct, if you will, our basic reimbursement system.

The problem with medicare and medicaid is not that they are in some way peculiar because they are Government programs. Their problem is that they are basically like private insurance systems. They act simply as a conduit of funds. They do not have, in spite of the tremendous sums of money, the bargaining power or the purchasing power in the community to get guaranteed performance, either financial or in terms of quality of care, from the providers. We have to reconstruct the reimbursement system to build in both the risks that are appropriate for those who engage in the provision of care and incentives for them to develop more cost-effective systems.

The political reality that we must all face is that we have an archaic, cumbersome, expensively administered health financing system that is increasingly unsatisfactory to the taxpaying public.

I thank you very much for your interest in this subject. We will cooperate in any way we can from California with any further inquiries you make into hospital organization and financing.

Thank you, Senator.

Senator **Heinz**. Mr. Moore, thank you.

I am just going to read one statement from Mr. Cory's prepared testimony that is quite consistent with what you said, but it is especially noteworthy and, like yours, an eloquent statement.

He says:

> George Bernard Shaw once commented that our willingness to pay surgeons more to cut off legs than to save them made him despair of political humanity. Economists who disagree on nearly everything—

And isn't that the truth—

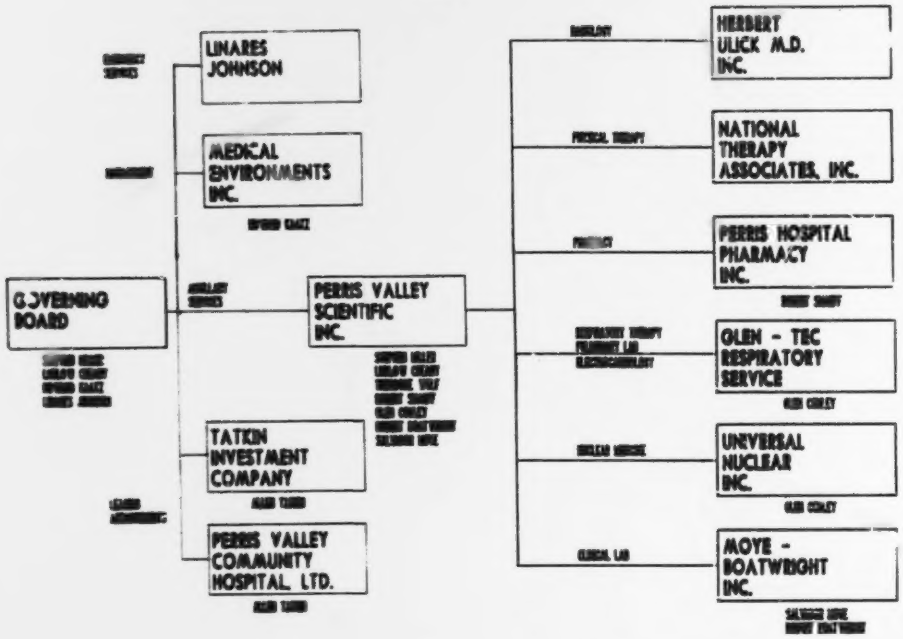
> have joined in a growing chorus of criticism of the way we pay for health care. Not only are the incentives wrong and the rewards backwards, the results are doubtful. Our reimbursement system guarantees that costs will go up, that devious corporate arrangements will proliferate to hide profits, that the medical-industrial complex will consume a steadily increasing share of our resources, and that health providers will continue to be rewarded not so much for preventing illness and maintaining health, but for the most radical and aggressive treatment of illnesses. It is ironic that this largest of our nonmilitary enterprises should be conducted without negotiation with those who provide the services, without full and candid disclosure as to costs and quality, and without requirements as to outcome.
>
> We pay for nothing else in our society with as little demand for performance as we pay for health care.

I think that is a very appropriate summation. Let us find out how it works.

Now, as I understand your testimony, you are saying that there was a family of related enterprises, over here [pointing to chart 1]; is that right?

Mr. **Moore**. Yes.

CHART 1


GOVERNING BOARD
LINARES JOHNSON
MEDICAL ENVIRONMENTS INC.
PERRIS VALLEY SCIENTIFIC INC.
TATKIN INVESTMENT COMPANY
PERRIS VALLEY COMMUNITY HOSPITAL, LTD.
HERBERT ULICK M.D. INC.
PHYSICAL THERAPY
NATIONAL THERAPY ASSOCIATES, INC.
PERRIS HOSPITAL PHARMACY INC.
GLEN - TEC RESPIRATORY SERVICE
UNIVERSAL NUCLEAR INC.
CLINICAL LAB
MOYE - BOATWRIGHT INC.

Senator HEINZ. And this being the governing board of the hospital. Can you tell us who the members of the governing board were and how they related to these other institutions—Stephen Miller, Howard Kaatz, and so forth?

Mr. MOORE. Two of the men, Mr. Miller and Mr. Kaatz, were a part of the administration of contracting agencies providing services to the hospital. As you can see, Mr. Miller's name turns up in several places as an owner or part owner of other organizations.

Dr. Creary and Dr. Johnson were involved in the direct provision of care. Dr. Johnson was the chief of emergency services at the hospital.

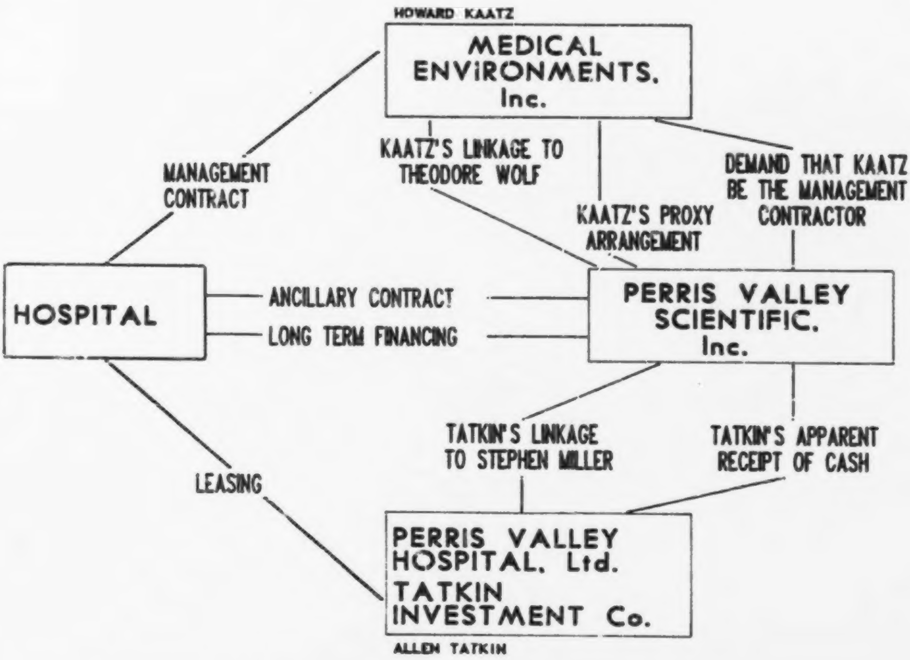
The arrangements here are fairly typical of those we have seen. One incorporating group puts together a governing body for a facility, and the members are virtually interchangeable with the governing body of a contractor which provides, or offers to provide, basic management services. In the case of Perris Valley Scientific, there is no evidence that they did very much. They really were not organized to do anything except act as a conduit and attach in their contract costs to the bills that came up from the related organizations. These other organizations, most of them, were incorporated primarily for the purpose of providing services to the hospital.

Senator HEINZ. So this hospital was just a shell. Everything was contracted out to a variety of organizations. For example, Perris Valley Hospital owned the land, owned the hospital, owned the equipment. The hospital owned nothing. It was all owned by Perris Valley, the principal of whom was a fellow named Allen Tatkin.

Mr. Tatkin was a lawyer involved in some of these other enterprises; is that correct?

[See chart 2.]

CHART 2


HOWARD KAATZ
MEDICAL ENVIRONMENTS, Inc.
MANAGEMENT CONTRACT
KAATZ'S LINKAGE TO THEODORE WOLF
KAATZ'S PROXY ARRANGEMENT
DEMAND THAT KAATZ BE THE MANAGEMENT CONTRACTOR
HOSPITAL
ANCILLARY CONTRACT
LONG TERM FINANCING
PERRIS VALLEY SCIENTIFIC, Inc.
LEASING
TATKIN'S LINKAGE TO STEPHEN MILLER
TATKIN'S APPARENT RECEIPT OF CASH
PERRIS VALLEY HOSPITAL, Ltd.
TATKIN INVESTMENT Co.
ALLEN TATKIN

Mr. Moore. That is right—and the ownership of the hospital, as I understand it, is still in the hands of that investment company, although the management has now changed; there is a new organization that has taken over the hospital since the other group declared bankruptcy.

But those arrangements, as you can see, provide complete management control over the facility at every level.

Senator Heinz. So what we have is a monumental example of "sweetheart" arrangements, with the hospital being only the shell, everybody dealing very profitably with them, not with the taxpayers, but with each other.

Mr. Moore. Apparently.

Senator Heinz. Now, let us take a look for a moment at the numbers from your investigation that show the results of this.

This column [pointing to column 2 of table C] is the 90th percentile of costs in the State of California, is that correct?

TABLE C
LISTING OF COST CENTERS FOR COMMUNITY HOSPITAL OF THE VALLEYS THAT EXCEED THE 90th PERCENTILE FOR 5th YEAR DATA

COST CENTER	90th PERCENTILE	PER UNIT COSTS COMMUNITY HOSPITAL	CONTRACTING[a] ENTITY
MEDICAL/SURGICAL ACUTE	$ 67.66	$ 75.23	-------
ANESTHESIOLOGY	1.32	2.18	-------
CLINICAL LAB	.94	11.61	PERRIS VALLEY SCIENTIFIC, Inc.
PULMONARY FUNCTION	11.57	57.96	PERRIS VALLEY SCIENTIFIC, Inc.
ELECTROCARDIOLOGY	20.43	34.45	PERRIS VALLEY SCIENTIFIC, Inc.
DIAGNOSTIC RADIOLOGY	6.47	37.51	PERRIS VALLEY SCIENTIFIC, Inc.
INHALATION THERAPY	15.93	40.06	PERRIS VALLEY SCIENTIFIC, Inc.
PHYSICAL THERAPY	13.75	24.89	PERRIS VALLEY SCIENTIFIC, Inc.
PRINTING AND DUPLICATING	34.50	67.57	-------
SECURITY	189.66	349.82	-------
COMMUNICATIONS	472.28	537.63	-------
HOSPITAL ADMINISTRATION	2,819.46	3,694.95	MEDICAL ENVIRONMENTS, INC.
PERSONNEL	271.22	304.99	-------
INSERVICES EDUCATION	32.24	64.36	-------

[a] THE NAMES OF CERTAIN CONTRACTORS ARE NOT DISCLOSED BECAUSE NO EVIDENCE WAS DEVELOPED OF ANY IMPROPER PRACTICES.

Mr. MOORE. That is right.

Senator HEINZ. That is to say, looking at the example of a pulmonary functions test, 89 percent of the hospitals in California would charge less than $11.50; 9 percent of the hospitals in California would charge more than $11.50. And yet, in this instance, Perris Valley Scientific, Inc., charged the hospital $57.96, or roughly five times, 500 percent more, than this, one of the substantially higher rates in the State of California.

Is that essentially how we should interpret this?

Mr. MOORE. That is exactly what that chart shows.

Ms. WILKINSON. Senator, I would like to correct the record, if I could, at this point in time. There was a misstatement—

Senator HEINZ. Would you identify yourself, first?

Ms. WILKINSON. Yes; I am Pat Wilkinson, and I am here as an attorney representing Allen Tatkin. Allen Tatkin is not now, nor has he ever been—

Senator HEINZ. We will have an opportunity for you to correct the record in a minute. Thank you.

Ms. WILKINSON. All right. Thank you.

Senator HEINZ. The clinical lab, up 1,200 percent, from 94 cents to $11.61.

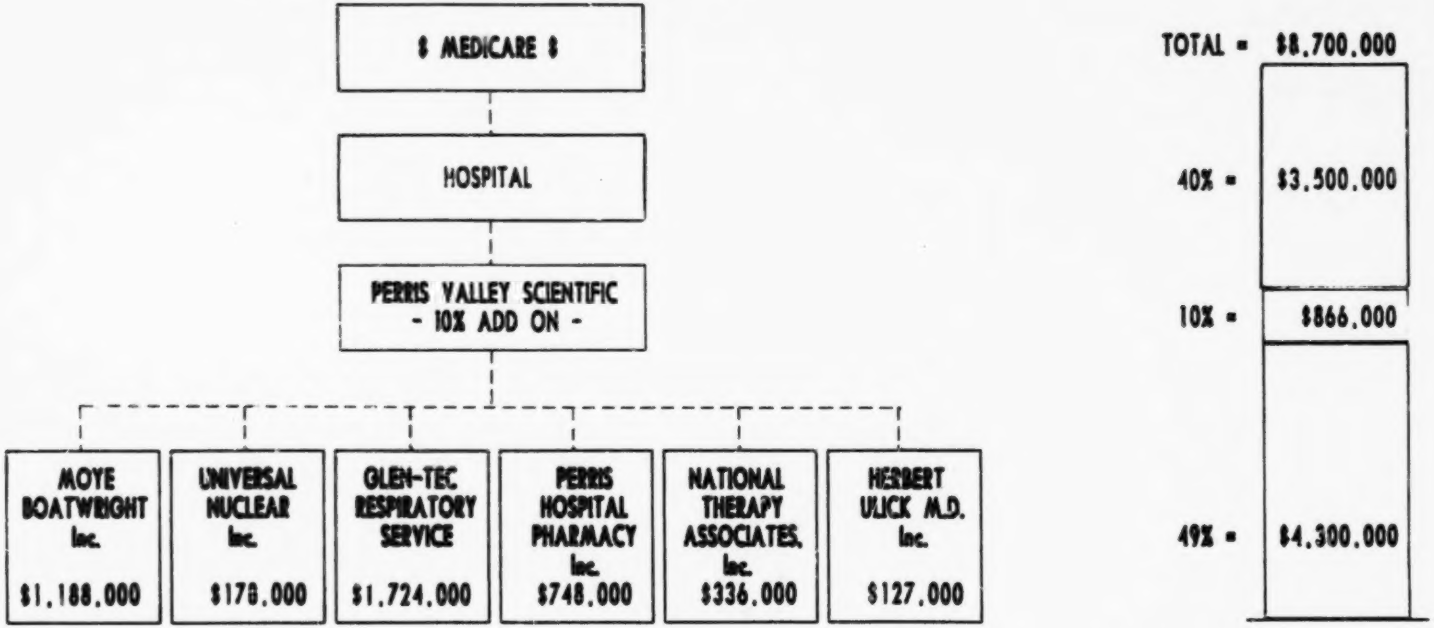
Someone will wonder what these blanks are. As I understand the blanks, these are instances where the service was contracted out to a noncontrolled company. It is nonetheless interesting to note that, taking something as normal as printing and duplicating, where the 90th percentile cost per unit was $34.50, that nonetheless, this institution did such a relaxed job, shall we say, of contracting out even for somebody whom they did not control, that the price was still twice, 100 percent more, than the 90th percentile cost, $67.57 rather than $34.50. Is that a correct interpretation?

Mr. MOORE. That is correct.

Senator **Heinz**. Now, as I look at this chart [see chart 3], which really comes from your investigation, we have here medicare, which paid during the period of time 1977 through 1980, $8.7 million. Looking at it from the ground up, these various control corporations funneled $4.3 million through Perris Valley Scientific. They added 10 percent, $866,000. And then, the hospital added 40 percent onto that and billed medicare. How on Earth did the hospital, apparently without having had to perform any of these services, bill for $3.5 million worth of additional costs?

CHART 3

1977 TO 1980 ESTIMATES OF PERCENTAGE ARRANGEMENTS AND CUMULATIVE DOLLARS FOR ANCILLARY SERVICES


$ MEDICARE $
HOSPITAL
PERRIS VALLEY SCIENTIFIC - 10% ADD ON -
MOYE BOATWRIGHT Inc. $1,188,000
UNIVERSAL NUCLEAR Inc. $178,000
GLEN-TEC RESPIRATORY SERVICE $1,724,000
PERRIS HOSPITAL PHARMACY Inc. $748,000
NATIONAL THERAPY ASSOCIATES, Inc. $336,000
HERBERT ULICK M.D. Inc. $127,000
TOTAL = $8,700,000
40% = $3,500,000
10% = $866,000
49% = $4,300,000

Mr. **Moore**. Well, it is a characteristic of the system that the primary biller justifies the charges based upon the documents that it submits or prepares, showing what its costs were. That is one of the fundamental flaws in the mechanism, is that we are unable as buyers, as public buyers generally, to look beyond that basic submission, or at least, rarely do, except in the case where, for other reasons, an audit or an investigative review takes place. As a routine matter, however, these things are rarely examined.

Senator **Heinz**. Well, as I understand it, these various institutions were actually located at the hospital.

Mr. **Moore**. Yes.

Senator **Heinz**. There was a supervisor or a president or whatever you want to call it, of those organizations, but the hospital personnel performed the work for the Perris Hospital pharmacy. Those personnel were on the hospital payroll, working for this little corporation here, so that, if you will, the taxpayers got billed twice for the same work—once by Perris Hospital pharmacy, for example, and then a second time by the hospital for the employees, which were hospital employees which provided some services free of charge to Perris Hospital pharmacy. Is that correct?

Mr. **Moore**. It appears that way. That is exactly what appears to have happened.

Senator **Heinz**. Well, as they say, appearances are deceiving, deceiving of the taxpayer in this instance, and that is us.

Let me just ask you another question. How did these financial manipulations affect the quality of care rendered by the facility?

Mr. **Moore**. In our role in this situation, we did not make an evaluation of quality. As you know, both the Professional Standards Review Organization in Riverside and the State Medi-Cal Administration both found many instances of what they considered inadequate or substandard care.

I will make an observation from my experience that is not, I hasten to say, strictly speaking, a matter of the policy of the controller's office, that for most of the years of the operation of these programs, medicare and Medi-Cal, there has been a corollary between financial organizations designed to make the most out of the flow of money and indifference to poor quality of care. It is hard to put together what I consider an excessive profit motive with high quality care and consistent patient protection. In this case, the organization has well-documented problems in patient care, as well as well-documented problems, from the taxpayer's point of view, in its financial management. I think they frequently go together.

Senator **Heinz**. Mr. Moore, thank you.

I am going to go briefly up to my Finance Committee hearing. Senator Percy is going to chair in the interim, has offered to chair, and I am very grateful to him, during my absence. I know he has a question he wants to ask you, and I will come back as quickly as circumstances permit.

So, Senator Percy, let me turn the gavel over to you; as a longtime ranking member of this committee, I know I turn it over into extremely experienced hands.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator **Percy** [presiding]. Thank you, Mr. Chairman, and I want to commend you before you do leave for this second in a series of recent hearings on the subject of medicare and medicaid abuse.

While you are gone, I will take the time to give my opening statement, which pertains to the problems we face in the State of Illinois.

I will ask just one additional question at this point for the continuity of the record. In 1979, the Professional Standards Review Organization cited the hospital for overutilization, inadequate care, inadequate supervision, and outmoded equipment. Two years later, some of these same deficiencies were cited by the health department in suspending the facility after the publicity resulting from the inordinate number of deaths at the hospital.

Is it your judgment that some of those who died last spring would still be alive if the hospital had been organized to be less concerned about reimbursement and more concerned about the patients it was supposed to serve?

Mr. **Moore**. I cannot honestly say, Senator Percy. I really do not know. That is a judgment that would have to be made by a medical review. It is an inference that one is tempted to draw from the circumstances, but I back away from going that far.

I will repeat what I said a moment ago, however, and that is that in the history of these programs, it has been my experience that there is frequently a corollary between elaborate and devious financial arrangements and substandard care. I have seen it repeatedly, not only in hospitals, but in prepaid programs, in nursing homes, and in other kinds of health facilities.

Senator **Percy**. I asked that question on behalf of Senator Heinz.

I have no further questions for either of you, and thank you very much for being with the committee today.

At this time, I would like to comment, as I indicated, on the Illinois hospital audit project dealing with medicare and medicaid reimbursement.[1]

This project, which was initiated at the request of the State of Illinois, involved the Inspector General as well as the Health Care Financing Administration and the Illinois Department of Public Aid. The project looked at four major areas of medicare and medicaid reimbursement—patient charges, hospital-based physicians, third-party liability, gifts, and grants. The evaluation shows that despite all we have done to improve the reimbursement system, major deficiencies, which are costing the Federal Government millions of dollars, still exist.

Among the findings in Illinois at 13 hospitals, inaccurate records resulted in a net overcharge to medicare and medicaid patients of $533,389.

Forty-six percent of hospitals did not maintain logs of patient charges for medicare and medicaid.

Sixty-nine percent of hospitals reviewed could not locate individual patient records, and 23 percent could not find a substantial number of patient medical records.

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[1] See footnote on page 4.

Seventy-nine percent of hospitals reviewed made significant errors in reimbursement of hospital-based physicians.

At just two hospitals, material errors in the calculation of reimbursable physician compensation resulted in an $806,035 error.

Ninety-six percent of hospitals made no attempt to identify third-party liability for services to eligible needy patients under medicaid.

Seventy-six percent of hospitals reviewed incorrectly treated contributed income or did not adequately document gifts and grants.

About $165 million was paid to hospital-based physicians in Illinois for fiscal year 1978 by the medicare and medicaid programs. If proper enforcement of regulations was to result in a disallowance of even 10 percent, there would be a program savings of some $16.5 million.

About $293 million in medicaid reimbursement was paid to providers for in-patient services during fiscal year 1978. If an additional 1 percent of medicaid payments could be recovered from other third-party sources, the medicaid program in Illinois could save some $2.9 million in 1 year.

About $500 million was donated to Illinois hospitals in fiscal year 1978. If only 1 percent was identified as restricted, the medicare and medicaid programs could save $2 million.

I would like to emphasize again that the problems and errors found by this audit project are not unique to Illinois, but have been found in audits of hospitals in other States, as well.

We could well ask ourselves the question, then, who is to blame for these problems and errors. Is it the hospitals, the intermediaries who administer reimbursement for part A of the medicare program, HCFA, or is it the Congress who created the system.

I think in all of these areas, we have to look at what the problems are here in the Congress, because we have created some of these problems in the way we have set up the system.

The Illinois study draws no conclusions about the future of the cost reimbursement system we now have. It does, however, conclude that most of the existing problems stem from lack of clear procedure at the Federal level and the inability of intermediaries, because of severe financial restraints or absence of documentation, to perform the necessary audits.

The study recommends numerous clarifications in definitions and policy to avoid costly mistakes and urges beefing up auditing requirements and procedures, recommendations about which I hope to question our witnesses.

After reviewing this Illinois project report myself, it seems entirely appropriate and reasonable to question whether we have the ability, given the enormous complexity of the system, its size, and our own shrinking resources, to improve it. Can we stop the drain of Federal dollars that go to pay bills we do not owe?

At a time when the Federal Government cannot even pay the bills it rightly owes, and the Federal deficit is projected to hit $100 billion this fiscal year, perhaps we should consider a new way to pay our health care bills.

The committee really now has a great responsibility to carry out its oversight in this area. It is a committee that has specific responsibility. We are not only an advocacy committee, in a sense, for the rights and privileges that we expect the elderly to have in this country, but we also have a duty and an obligation, as we fight for those rights, to make absolutely certain that what is spent is spent as efficiently as possible. This will become a far greater problem in future years as the percentage of older persons grow.

In accordance with the committee rules, the principals of the Community Hospital of the Valleys have been informed that testimony would be presented at this hearing which could prejudice their interests. They were informed of their right to be present and respond, submit to sworn statement, or provide questions in writing to be used in cross-examination. One of the principals, Stephen Miller, is present. Allen Tatkin is represented by counsel, Pat Wilkinson, who is prepared to submit a sworn affidavit for Mr. Tatkin for the record. Howard Kaatz has chosen not to appear before the committee. He requested that the committee be informed that Medical Environments, Inc., and its officers have not been contacted by anyone from the controller's office concerning this investigation. Mr. Kaatz will provide a formal response for the record.

Would Mr. Miller and Ms. Wilkinson please come forward?

Mr. Miller, under committee rules, your testimony must be submitted under oath. If you would be good enough to stand and raise your right hand, do you solemnly swear the testimony you are about to give before the committee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. MILLER. I do.

Ms. WILKINSON. I do.

Senator PERCY. Please proceed.

STATEMENT OF STEPHEN K. MILLER, ESQ., PRINCIPAL, COMMUNITY HOSPITAL OF THE VALLEYS, PERRIS, CALIF.

Mr. MILLER. Thank you, Mr. Chairman, for the opportunity to attend this committee hearing and for the opportunity to rebut the report submitted by the controller's office.

If I may be permitted, Mr. Chairman, to read a rebuttal to the report, it is not lengthy—it is about 10 pages of handwritten notes—but I think it sets forth with some degree of particularity the specific problems inherent in the Community Hospital of the Valleys, and primarily the fact that the controller's report was incomplete and biased in its investigation.

Kenneth Cory, controller of the State of California, has submitted to your committee a document entitled, "Review of the Business Relationships of Community Hospital of the Valleys" and has asserted therein that this hospital is a prime example of the abuses in the medicare/Medi-Cal system. I do not know the motivation of Mr. Cory in singling out this small rural hospital, but I wish the committee to be advised that this report, while containing some factual data, is incomplete and biased and does not present a fair and impartial analysis of the business structure and, in fact, draws false and misleading conclusions that Community Hospital of the Valleys, Perris Valley Scientific, Medical Environments, and the building lessor have conducted improprieties ostensibly for the purpose of defrauding the medicare and Medi-Cal systems. Nothing can be farther from the truth. Either Mr. Cory is misinformed as to the whole picture, or he is attempting to gain political advantage by crucifying a small medical facility and those who are involved with it. He has totally missed the main problem area with which this committee should be aware—that of the grossly disproportionate expenses of a small rural hospital, primarily catering to the needs of the elderly, as contrasted to the operation of a large metropolitan hospital. Neither medicare nor Medi-Cal make any such differentiation.

The report is so biased that it should be noted that Mr. Cory or his staff never attempted to contact me, any officer, director, shareholder or attorney at Perris Valley Scientific, Mr. Kaatz, nor the lessor of the hospital land and buildings, to determine the perspective in which the data obtained from fiscal intermediaries and Kenneth Hahn should be judged. This fact is admitted by Mr. Cory on page 31 of his report.

While I would welcome the opportunity to attack the report on a point-by-point basis, it would serve no real function in these committee proceedings. Rather, in an attempt to defend the names and reputations of those people Mr. Cory is so willing to sacrifice in his own benefit, I will deal only with the overall nature of the hospital to give the report some perspective.

The most important omission from this report has to do with the history and establishment of the hospital itself. Perris, Calif., is one of a number of small cities about an hour away from Riverside, Calif., a small-to medium-sized city. The community is largely agricultural, and the demographics indicate that the population is older than average, and in fact, approximately 15 minutes farther away from Riverside is Sun City, Calif., primarily a retirement community.

The hospital was owned and built in 1972 by a small group of physicians. In 1974, when they were unable to keep the facility open, the hospital closed and fell into the grips of the Bankruptcy Court. The builder of the hospital, who had also financed it, foreclosed, and then became the owner of the facility. Later that same year, the hospital was leased to Lakeview Hospital, Inc., a Los Angeles-based firm which thereupon reopened the facility. However, less than 2 years later, the hospital again failed and left the community served by the hospital with no medical care center within reasonable access.

During the last quarter of 1976, the owner of the land and buildings sought diligently to locate another hospital operator to lease the hospital and reopen. In view of the previous failures and the anticipated continuing financial problems connected with the exceptionally high costs attendant to a small rural hospital, especially one which is largely dependent upon governmental subsidy, no established firm in the hospital industry was willing to take on this white elephant.

During this time, Howard Kaatz, who had been previously retained by Lakeview Hospital during its last days to save their venture, was contacted by Dr. Linares Johnson, a local physician, who encouraged Mr. Kaatz to take the hospital over himself. However, there were two major stumbling blocks to be overcome. First of all, a new hospital needs substantial seed money to get started, and second, the prior failures of the hospital were widely attributed to the inept and nonlocal management provided by the prior operators.

Mr. Kaatz presented the idea of raising the startup capital from providers of ancillary services, who he felt, would be willing to loan the funds if they would be awarded the ancillary service contract. These contracts, he assured Dr. Johnson, would be fair and at arm's-length, based upon what the hospital would reasonably anticipate entering into with any provider of quality services in this rural area. It should be stressed that at this time, the hospital was closed, and had a flakey reputation, and there was nobody around who would offer a better ancillary percentage, considering the large risk involved in getting paid at all.

Rural hospitals of this size cannot afford, on the whole, to provide the expensive equipment and professional personnel to operate in-house these ancillary departments, and accordingly contract for these services from companies who are able to provide them to a number of facilities to make it cost-efficient.

Dr. Johnson, who had been a major user of the hospital, was reluctant to hospitalize his patients so far from home, and felt that this was a reasonable format, but insisted that the providers commit to provide their services on a long-term basis to establish a solid foundation for the new facility. Hence, the 15-year contract.

In order to establish the credibility of the hospital with the community, which had become leery of nonlocal ownership as a result of the Lakeview Hospital incident, Mr. Kaatz suggested that the hospital be operated by a nonprofit corporation, made up and controlled by local people, who could insure that the hospital would be responsive to the community needs. This was heartily agreed to by Dr. Johnson, who sought out community leaders to serve on the hospital's governing board.

Mr. Kaatz thereupon contacted the owner of the land and buildings and proposed that the facilities be leased to a to-be-established nonprofit corporation on exactly the same terms as had been involved with the prior lessee. This was acceptable, provided Mr. Kaatz would personally guarantee the lease, which he did.

Finally, Mr. Kaatz contacted numerous providers of ancillary services to provide ancillary services and financial backing for the hospital. In Mr. Cory's report, he alleges that no competitive bidding took place. This is not true. Mr. Kaatz, in interviewing numerous ancillary providers, did just that. Only the best of these offers were accepted. The ancillary providers agreed to provide the services in a professional manner and solely in exchange for a percentage of gross billings. If the hospital census was low, little ancillary services would be needed, and the providers would likely lose money. On the other hand, as the community grew, the census of the hospital was anticipated to increase, thereby providing a profit potential for their capital and services. All costs of maintaining the departments were not the responsibility of the hospital, but the providers—which was another "mistake" that Mr. Moore testified to—other than the cost of providing workspace at the hospital.

The typically 35 to 40 percent of gross billings of ancillary services being retained by the hospital was far more than compensatory for this space. In all of the ancillary contracts ultimately executed, each provider agreed to charge reasonable fees for services provided, and to my knowledge, there has never been any allegation that there were excessive charges. In fact, the contracts even include a provision charging back to the provider any excess charge.

The providers also requested the same option to purchase the land and buildings upon the completion of the initial 5-year term of the lease, at the same price and terms as the owner had granted Lakeview Hospital previously.

Perris Valley Scientific was formed to provide a single entity to provide, or arrange to provide, all of the ancillary services. It undertook the task of raising sufficient funds to get the hospital started, and later acted to provide substantial additional financing by way of accepting deferred payments for services rendered. It recruited the initial and replacement providers. It acted as the single billing agent to the hospital for the purpose of expediency and uniformity of all contract providers. It acted to monitor the quality and timeliness of the ancillary services. It advised the hospital's governing board with respect to additional equipment and services which could be utilized by the hospital, most of which were actually provided by PVS. And it assisted in the cost reporting and other financial functions of the hospital. It sought to improve the hospital's image and attempted and succeeded in attracting new physicians to the medical staff. In exchange for these services, it received a fee equal to 10 percent of the ancillary services provided.

Perris Valley Scientific as a lender of nearly a quarter of a million dollars of startup funds to the hospital, reasonably requested that it be protected in its investment. It requested Mr. Kaatz, or an entity which could provide his services and the services of other expert consultants in various areas, to be retained to provide management for the hospital. Please note that Mr. Kaatz has never had an equity interest in PVS and was selected by PVS based on his many years of hospital administration. Dr. Johnson and the other members of the governing board wholeheartedly agreed, since it was he who had wanted Mr. Kaatz to run the facility. In view of the legal and administrative complexities of hospital management, and as is common with rural hospitals, a local board of directors could not be expected to be cognizant of or proficient in this specialized area.

In addition, there were at that time few, if any, management companies who would undertake this function solely on a percentage basis. It should be noted that Mr. Hahn, who was an individual who was later retained by the hospital after Mr. Kaatz was discharged for allegedly improper conduct, was paid approximately $150,000 a year for approximately a half-time job, regardless of hospital revenue.

PVS further required normal assurances that any creditor of a sizable amount would need, such as obtaining a security interest in the hospital's assets until it was paid back its loan. It was relevant to point out at this juncture that PVS has never received any payment on its loan, either principal or interest.

Let me stress that all of these agreements had been negotiated, prior to the creation of a nonprofit corporation. Had it not been for the provider's equity loan, the hospital would never have been opened.

All these facts and arrangements were freely and openly disclosed and discussed with all Federal and State agencies at the onset. The arrangement had been carefully pieced together, was submitted to a respected CPA firm specializing in cost report consultation, and was fully approved in concept and practice prior to the establishment of the entities and the execution of the agreement. From the time the hospital opened, until it closed 4½ years later, the governing board, of which I was the only PVS-affiliated member—a fact which was clearly known to everyone—was made up almost entirely of local business and professional leaders, and efforts were always being made to broaden the base of local leadership. The governing board acted for the most part totally independent of PVS, which stood by to assist the hospital's growth. It was PVS that obtained the financing for the construction of the cardiac care unit and numerous other additions to the hospital. The board and PVS had relatively few operating disputes, and those were primarily brought on by the medicare and Medi-Cal audits, which took the inflexible position that PVS was some kind of devil. The intensity of these disputes underscored the independence of PVS from active control of the hospital.

All services to be provided by Kaatz and PVS were conditioned upon excellence and reasonable charges. The contracts were always subject to attack by the board, if there were any failures to meet these standards. This fact can be attested to by the act of the board to terminate Kaatz's contract as a result of his allegedly unauthorized loan to Lincoln Hospital, which was contained in Mr. Cory's report. While the loan did not directly benefit Kaatz, he repaid the same from his own funds.

Notwithstanding this incident, PVS wished to continue with Mr. Kaatz, but with more control. The board, acting on its own, terminated the contract. This is additional evidence that PVS did not control the board. The new management consultant hired by the board, Kenneth Hahn, from whom Mr. Cory's office seems to have obtained much data, including incorrect and misleading accounts of PVS, was himself concerned about his own behavior at the hospital, and failing to locate the cause and contact local authorities when the deaths assumed a disproportionate level.

PVS was worried about Mr. Hahn's lack of backup—he was acting alone in this position—and his never-ending demands for more and more money and other benefits. It was he who allowed the hospital's malpractice insurance to lapse after I had resigned from the board due to lack of funds, and thereafter demand an additional bonus of $6,000 for exceptional service. This lapse cost the families of numerous benefits as a result of the deaths which took place at the hospital and for which a criminal proceeding is underway.

In summary, it was, is, and will continue to be the position of both the hospital and PVS that PVS was not a related party; PVS never exercised any control over the hospital other than that which any major, secured creditor would exercise, and it is for that reason that the hospital never asserted the existence of a related party relationship.

The business structure of the hospital was established for the sole purpose of raising capital, and yet maintaining the control by the community which the hospital served. This structure was made in good faith and with professional blessings.

But what is the real lesson here? First of all, you cannot compare a small rural hospital with a large metropolitan hospital. The resource needs are similar, but the revenue source is, under current rules, far less. Perhaps the answer is to do away with the small local facilities and assume the risk inherent with emergency facilities 1, 2, or more hours away. I would strongly disagree with this.

An alternative may lie in the ever-antagonistic attitudes assumed by medicare and Medi-Cal in making such complex restrictions on the ability of a small facility to render services to the aged and needy. Virtually every small hospital of which I am aware has had a continuing battle with the fiscal intermediaries, just to stay alive. And after years of advances, the hospital is audited, and everything including the kitchen sink is disallowed. There is no way a facility can get out from under this pressure, even though the bulk of the initial disallowances are later restored.

Perhaps there should be a bad faith doctrine to at least require the agencies to attempt to treat with fairness the facilities whose services are so badly needed. Private insurance companies are held to such a standard of care; why not the public ones?

Or, maybe the government agencies just do not have the necessary funds to provide what is needed, so by tightening the belt, they enrich the large and metropolitan hospitals and force the smaller and more needy facilities out of business.

That is a sad commentary.

Thank you.

Senator PERCY. Thank you, Mr. Miller.

Ms. Wilkinson, perhaps it would be appropriate to give your affidavit now on behalf of Mr. Tatkin.

STATEMENT OF PAT WILKINSON, ATTORNEY, REPRESENTING ALLEN TATKIN

Ms. WILKINSON. Thank you, Senator Percy.

First of all, I would like to correct a misstatement in the record which angered me at the time it was made, and it was made, I am sure, carelessly, and with no malintent on the part of Senator Heinz.

He referred to my client, Allen Tatkin, as an attorney, an attorney connected with Perris Valley Hospital. Such was never the case. My client, Allen Tatkin, is not now, nor has he ever been an attorney. He never provided the services of an attorney in connection with Perris Valley Hospital.

Because of Mr. Tatkin's health, he was unable to attend today, so I will read his sworn declaration in place, instead, of his personal appearance:

> I, Allen Tatkin, having been previously sworn, do hereby declare and state that the following facts are based upon my personal knowledge, and if called to the witness stand, I could and would confidently testify under oath as follows:
>
> (1) That on Friday, March 5, 1982, I was advised for the first time that the U.S. Senate Special Committee on Aging was preparing to investigate certain matters involving Community Hospital of the Valleys, and that Kenneth Cory, California State Controller, would be testifying at a hearing scheduled for Wednesday, March 10, 1982;

(2) That in 1972, I was president of Hospital Finance Corp., which built, or caused to be built the hospital known in 1972 as Perris Valley Community Hospital, subsequently known as Community Hospital of the Valleys;

(3) That from 1974 up to and including 1981, Hospital Finance Corp. was the general partner of a limited partnership which owned the buildings and the real property of the hospital in question;

(4) At all times from 1972 to 1981, I was the president of Hospital Finance Corp. and as such was in charge of negotiating the lease of the real property and buildings which comprised the hospital in question;

(5) On or about December 29, 1975, Hospital Finance Corp. leased the real property and buildings of the hospital in question to Community Hospital of the Valleys, a nonprofit corporation. From 1972 to 1981, Tatkin Investment Co., a California corporation, leased personal property and a medical building to Community Hospital of the Valleys and its predecessors. The leases were set at a fixed rental rate. At all times mentioned herein, I was president of Tatkin Investment Co.;

(6) Community Hospital of the Valleys leased the hospital premises for a 5-year period, at the same monetary rate as the prior lessee of said hospital, which was Lakeview Hospital, a California corporation, leased it for;

(7) That at no time did Hospital Finance Corp. or Tatkin Investment Co. or anyone acting on their behalf agree to provide or provide any medical, pharmaceutical, or other ancillary services to either Community Hospital of the Valleys or Perris Valley Scientific, nor did Hospital Finance Corp. or Tatkin Investment Co. ever receive any payment for the rendition of said ancillary services;

(8) That on or about July 1981, I, as president of Hospital Finance Corp. and Tatkin Investment Co., sold the real property, improvements, and personal property here and above referred to;

(9) That neither I nor Hospital Finance Corp. nor Tatkin Investment Co. were ever involved in the financial or working relationship between Community Hospital of the Valleys and Perris Valley Scientific or in their administration;

(10) That at no time have I or anyone else, acting on behalf of Hospital Finance Corp. or Tatkin Investment Co. ever spoken with Kenneth Cory, California State Controller, or a representative from his office concerning Community Hospital of the Valleys or any matter relating to the operation of the hospital;

(11) That at no time has Kenneth Cory, California State Controller, or anyone acting on his behalf, ever asked to speak with me or anyone acting on behalf of Hospital Finance Corp. or Tatkin Investment Co., concerning Community Hospital of the Valleys or any matter relating to the operation of the hospital;

(12) That, although my present ill health will not permit me to travel to Washington, D.C., I will be available to answer any and all questions that the Senate committee may wish to propound by way of either written interrogatories or oral deposition taken in Los Angeles, Calif.

Executed this 8th day of March 1982, at Los Angeles County, Calif.

Signed, Allen G. Tatkin.

Senator **Percy**. Thank you very much, indeed.

Mr. Miller, the controller has indicated you incorporated both the Community Hospital of the Valleys and Perris Valley Scientific on the same day. Could you tell this committee why this was done on the same day?

Mr. **Miller**. Yes, Senator.

The negotiations which led to the total structure had been conducted over a period of several weeks that preceded the organization of these entities. It was the establishment of all of the entities together which was able to cause the formation of the hospital in the first place. Had the ancillary providers not been willing to loan the working capital to the hospital, the hospital would not have any assets and would not have been able to open. This was the vehicle for which the hospital was permitted to conduct business.

So all of these documents and agreements had already been made; then it was just the preparation of the entities, and completion of the entities, and so forth. At that point, it was administerial.

Senator **Percy**. Did you also at the same time, at that particular time, represent Allen Tatkin?

Mr. **Miller**. Yes, I did.

Senator **Percy**. What fee did you receive for incorporating and organizing the two companies, and could you tell the committee who paid the fee or fees?

Mr. **Miller**. The total fee charged for preparing all of this work was $7,500, of which $4,600 was paid by the nonprofit corporation for organizing the entity, obtaining the exemption, and preparing and revising all agreements and leases. And $2,900 was paid by Perris Valley Scientific for organizing the same and reviewing the subcontracts. I received no fee from Mr. Tatkin in this transaction at all, ever.

Senator **Percy**. Could you, then, check your own records and supply the exact figures to the committee——

Mr. **Miller**. Yes, I can.

Senator **Percy** [continuing]. And reaffirm that no fee was paid by Mr. Tatkin?

Mr. **Miller**. Yes, Senator. I hereby reaffirm that no fee was paid by Mr. Tatkin.

Senator **Percy**. Subsequently, you did serve as a member and president of the hospital's governing board. You also were a principal of Perris Valley Scientific. What was your role in these two organizations, whom did you report to, and how were you compensated?

Mr. **Miller**. I was never an officer or director of Perris Valley Scientific, although I was a shareholder and an investor with that entity. I owned at that time, and still do, approximately 12 percent of the outstanding stock of Perris Valley Scientific.

At the time of the creation of the nonprofit corporation, I was requested by the governing board to serve on the governing board, both to add additional input to that entity, and to represent the interests of Perris Valley Scientific, which was the major creditor of that entity at that time. This relationship was known by all sides and was acquiesced in, all in advance.

Senator **Percy**. Were you at that time in the employ of Mr. Tatkin or any other party affiliated with either the Community Hospital of the Valleys or Perris Valley Scientific?

Mr. **Miller**. No, sir. I was representing Mr. Tatkin in other matters and was concerned that the operating entity would be able to make a go of the facility at this time and thereby eliminate further anxieties and complications to Mr. Tatkin, who merely had built the building and was a lessor of it. After the prior failures and the hospital closed, there was nothing he could do with it, and he had a substantial investment involved in the property.

So it was the establishment of this group which was necessitated by the fact that the prior history of the facility was shoddy and that no one was around, willing to take over the facility to render the services that were so desperately needed in that area.

Senator **Percy**. Based on the Perris Valley preincorporation agreement, the controller alleges a conspiracy of financially—related parties structured to maximize reimbursement from medicare and Medi-Cal. What is your response?

Mr. **Miller**. At the time the structure was agreed upon, Senator Percy, I personally had no knowledge or insight into the reimbursability of this arrangement. This was tended to by Mr. Kaatz, who had been involved in the hospital industry for years, and he had passed the proposed structure before a CPA firm that had had many years of experience in cost reporting consultation, and they agreed that this format was a fair one and one which would not create abuses with the system.

At no time did we ever hold anything back. This was a system that was agreed as an only way of getting this hospital reopened in an area when the hospital needed to be there. The census was low, although we all felt that the community was growing and that ultimately the hospital would be self-sustaining. In fact, at the time that the hospital went into bankruptcy, there was in excess of $1 million owing for ancillary services that had been provided, and very honestly, it was the ancillary services that provided the income to the hospital itself, rather than the room rates, because of the far greater proportion of revenue to the hospital than it itself drew from the hospital.

Senator **Percy**. Three other hospitals went bankrupt in Perris, Calif. Were you involved in any way with those facilities?

Mr. **Miller**. No, sir. I have not ever been involved with any other hospital.

Senator **Percy**. I thank you both very much, indeed.

We will now go to a panel including Bryan Mitchell, Deputy Inspector General, U.S. Department of Health and Human Services, and Barry Friedman, chief assistant deputy attorney general, medicaid fraud control, State of New York, New York, N.Y.

Mr. Mitchell, if you would please go right ahead, we would be happy to have your testimony. We welcome both of you here and appreciate your appearance.

STATEMENT OF BRYAN MITCHELL, WASHINGTON, D.C., DEPUTY INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. **Mitchell**. Thank you, Mr. Chairman.

Inspector General Richard Kusserow regrets very much that he is unable to attend this hearing this morning.

Mr. Chairman, I am very much appreciative of the opportunity to appear before this committee to discuss problems associated with the reimbursement of hospitals as disclosed by the projects in California, New York, and Illinois. When the Inspector General's Office was first formed, it became apparent that little was known about fraud, abuse, and waste in hospitals or had been done to control these problems. The efforts in California, New York, and Illinois represent initiatives to remedy this lack of activity, and I believe you will find that progress has been made.

You have already heard from Mr. Moore, representing Controller Cory, on the details of the California investigation which, as you know, was funded by our office. You will also be hearing a description of the New York project, which was funded and monitored by the Health Care Financing Administration and the Inspector General's Office.

This morning I have a dual role. First, I will describe the Illinois hospital audit project, which is our third major probe into the hospital area. After that, I will discuss how the Inspector General's Office is making use of the efforts we have made thus far to mount an overall offensive against fraud, abuse, and waste in hospitals.

Turning to the Illinois hospital audits, with which the chairman is very familiar, the study was started in 1978 because of dramatically increasing health costs, particularly in hospitals. The fundamental purpose of the study was to find out if the audit mechanism in place for medicare and medicaid was successful in assuring the payment only of proper costs for covered services.

Illinois was selected as the location for the study for a number of reasons. First, the State was clearly concerned about hospital costs and had expressed a strong interest in a study of this kind. Also, the medicare and medicaid programs in Illinois operate under a common audit agreement under which the medicare intermediary performs both medicare and medicaid audits as a cost savings measure. Further, the State has a large number of hospitals of various sizes and in various localities.

Because the project was designed as a joint Federal/State effort, the planning phase of the project was conducted by a specially designated group consisting of HCFA, State public aid, and OIG staff. The team identified four significant audit areas to be studied, created audit guides, selected a sample of 34 hospitals, and performed field testing of the audit guides in three sample hospitals. The Federal/State team also selected seven independent firms to perform the actual field audits. After the audits were completed, their results were analyzed in the study report which has been made available to the committee. I would like to summarize the most significant general findings that came out of the study.

Most generally, the study revealed basic deficiencies in the medicare/medicaid policies and procedures in all of the areas audited. Such deficiencies were uncovered in most of the hospitals audited, and regardless of the audit firm performing the individual audit.

Another important finding is the poor maintenance of hospital and physician records in spite of the fact that true medicaid and medicare costs cannot be accurately determined without such records. For example, 64 percent of the hospitals could not produce all the records and documents requested by our audits, and in 88 percent of the hospitals, physicians' time and effort allocated could not be objectively documented.

A third major finding flows directly from the finding of poor hospital records. The study raised serious questions as to the depth of the intermediary audit and the management of the intermediary audit process. Thus, deficiencies were found in 100 percent of the hospitals in identifying and reporting third-party receipts although all these hospitals had been previously audited by the intermediary. In 92 percent of the hospitals, reviewers found substantial errors in patient charges, strongly indicating inadequate intermediate testing of these records.

At least part of the explanation for the superficiality of the intermediary audit was the finding in a number of hospitals that intermediary auditors had spent their time in reconstructing hospital records rather than in auditing those records. This misuse of the scarce audit dollars is particularly troublesome, in view of the fact that the State has established a penalty for hospitals which do not maintain auditable records, but the intermediary has not seen fit to apply the penalty to even a single hospital, regardless of the condition of the records.

Another major finding which was uncovered by the study was the universal confusion and conflict among providers as to the guidelines and instructions issued by the State and the Federal Government. Auditors found widespread differences in the understanding of the basic terms, such as "hospital-based physician" and "restricted" gifts. This confusion indicates a major need for the clarification and simplication of the guides.

Obviously, Mr. Chairman, your committee is interested in the monetary impact of these findings. During this study, it was estimated that the pattern of the sample hospitals, assuming the deficiencies are validly projected statewide, would amount to over $20 million per year in incorrect payments to the State of Illinois alone. A gross projection of the problems uncovered in Illinois—once again, is typical enough for a national projection—indicates potential program savings of over $500 million per year nationally.

We have been asked to mention briefly what we are doing as a result of the Illinois study, as well as the projects in New York and California.

With respect to the results in New York, Mr. Friedman in his remarks will describe for you the comprehensive audit and investigative manuals his office developed. These manuals were specific deliverables of the contract between our department and the New York special prosecutor's office. They were intended to be used for training other investigators and for use by units throughout the country in investigation of hospital fraud and abuse. Following their development, training sessions were held in strategic locations throughout the country for staffs of medicaid fraud control units and other investigators; copies of the manuals were distributed to the medicaid fraud control units and other medicare/medicaid investigative units. The California report, as you know, was only recently received in draft by our staff, but we were quite impressed by the targeting methodology developed in that project, and are already making arrangements to make targeting methodologies of this kind available to investigative units in all States. We are also moving vigorously to apply the review patterns developed by the Illinois report to other States. As a first step, we have met with HCFA officials and have reached initial agreement on a number of actions HCFA will take immediately, including the designation of the problem areas for priority audit by other intermediaries, and a systematic reporting of the results of these audits.

Beyond these specific measures, I am pleased to tell you that the Office of Inspector General will devote significant additional resources in counteracting trends in medicare and medicaid that not only place the programs in financial jeopardy, but which continue to make them susceptible to fraud, abuse, and waste. In a series of major new initiatives, we will focus our efforts on rooting out provider fraud and abuse; promoting opportunities to save funds through tightened fiscal control; and in promoting effective management of programs by the various organizations responsible for policy setting, funds dispersal and quality control.

Within the Office of the Inspector General, the Inspector General is forming a Health Care Financing Division in each of the principal components of the organization. That is, in audit, investigations, and in systems integrity. This will permit the Inspector General to bring to bear the skills of auditors, investigators, and program analysts working together to deal with significant problem areas in the medicare and medicaid programs. We have identified over 20 specific areas for concentration of our initiative. These include such service areas as end-state renal disease payments, laboratory payments, and emergency medical services payments.

Our initiative also includes the review of current devices for cost control such as the cost report and settlement process and careful consideration of alternative payment systems, such as competitive contracts and prospective reimbursement, which are proposed as alternatives to the present reimbursement system.

During the current year, for each of the policy issues defined, we will develop, field test and complete the necessary investigation and audit guides that will be required for in-depth review of hospitals. When fully developed, the Inspector General's initiative will be a nationally directed investigation of hospital medicare and medicaid delivery systems throughout the Nation. Our initiative will focus a significant portion of the OIG's resources in an intensive review of immediate and longer range issues affecting the integrity and efficiency of the medicare and medicaid systems.

I believe, Mr. Chairman, that there is complete consonance between what we have learned in Illinois, California, and New York projects and the design and thrust of the Inspector General's health care initiative.

Let me mention some of the things we learned from these projects and some of the ways we are putting our learning to use.

We learned that major studies of this kind could be successfully performed. Each of the areas studied had been looked at before, but there had previously been some hesitancy to explore them in the kind of breadth that was entailed by these projects. As a result, I believe the studies remarkably advanced our understanding of medicare and medicaid problems and provided a direction in which we could move to deal with them through a national initiative.

Another significant lesson that we learned from the Illinois study was the central importance of an effective intermediary audit activity in controlling program costs. Frankly, the results of the Illinois project raised serious questions in our minds as to the management effectiveness of medicare intermediaries. As a result, our initiatives will consider the entire medicare/medicaid system, not just the hospitals, but the way such organizations as intermediaries and carriers function to pay properly and to control costs. A major focus on our initiative will be the effectiveness of existing cost controls and the need to improve or supplement such controls.

Beyond many of these lessons, Mr. Chairman, all of our audits and studies reinforce for us the nature of the extreme complexity of the payment structure we are dealing with. At the first level, there is a very complicated set of reimbursement principles which define the proper cost to hospitals. To assure that actual payments conform to these principles, we have a complicated system of cost controls, reports, and audits. Both the reimbursement and audit activities are described in a seemingly endless number of guidelines and instructions issuing from different and, in some cases, contradictory sources. It has been estimated that in the State of Illinois, the State and Federal guidelines for hospitals fill about 50 volumes. The remarkable fact may be not that the system operates poorly, but that it operates at all.

Therefore, in addition to the immediate measures we are undertaking to deal with the system as it is, our initiative will focus on how the system could be simplified or streamlined so as to solve some of the problems which may be inherent in the present tangle of rules and guidelines. The Inspector General has discussed this matter with the HCFA administrators who share these concerns. We will be giving serious attention as to how this simplication could be accomplished.

I thank you, Mr. Chairman. We would be pleased to answer any questions.

Senator HEINZ [resuming the chair]. Mr. Mitchell, my intention would normally be to have Mr. Friedman present his testimony, but in view of the fact that you have presented testimony particularly with respect to the hospitals and hospital audits in Illinois, and in view of the fact that Senator Percy, I know, has to leave shortly, I would be happy to yield to Senator Percy for any questions that he might have of you.

Senator PERCY. I would very much appreciate that, Mr. Chairman. That is very thoughtful of you, as always.

I do have just a few questions, Mr. Mitchell.

First, may I ask how long you and the Inspector General have been on the job in your present capacities?

Mr. MITCHELL. I have been in the Inspector General's Office, Senator, since the day it was formed. The present Inspector General has been there since June 10, sir.

Senator PERCY. The Inspectors General were set up by the Governmental Affairs Committee, on which I serve as ranking Republican. I have long believed that the oversight responsibilities of Congress are haphazardly done. This committee has been doing them on a very methodical basis, but generally, we get around to it when there is a crisis. So, with the Inspector General, we created an internal auditing system in every single department, reporting directly to the Secretary, but not beholden to the Secretary in his other responsibilities.

Senator Roth, Senator Chiles, and myself spent many, many months establishing the system. Why is it, then, that these flagrant abuses are now coming to light? Wasn't it possible that they could have been discovered by the Inspector General before?

Maybe you could just tell us the kind of a load and problems you have with your huge department.

Mr. MITCHELL. There is no doubt about that, Senator Percy. The job that we have is tremendous, and the staff that we have is just simply inadequate to do the total job that has to be done, which is one of the reasons that we have worked in cooperation with other people, such as the New York special prosecutor, the medicaid fraud control unit, the controller of the State of California, and the State of Illinois.

I must be very frank, though, Senator Percy, in telling you that at the time the Inspector General's Office was put together, the pieces that went into putting the Office together—the formal audit function in the department and the formal investigative function—simply were not focusing on the matters that we are focusing on here today. The audit function was primarily one of a financial accounting audit, if you will, seeking to recover overpayments. The investigative force was very, very small and had absolutely no expertise in such matters as we are discussing today. I think Mr. Friedman will testify to the complexity of trying to conduct an investigation of a large hospital.

The chart on the wall that shows a very, very small hospital and the tremendous amount of work that the California controller's office had to put into this hospital, illustrates clearly the problem of finding fraud and abuse in these systems. It goes to what the chairman said in his opening remarks and to what you have reiterated, Senator that the reimbursement systems are so complex that they almost invite fraud and abuse and make it very, very difficult to get at them in any way at all.

One of the things we found very early on, sir, was that no one knew how to go about finding fraud and abuse in hospitals. When we found that the people in New York were beginning to get a handle on that, we very quickly joined forces with them, and I think we are now beginning to get a handle on those things. But these are only, in my view, sir, Band-Aids that help the system along, but don't really make the major changes that are needed.

Senator PERCY. But I think the emphasis you have placed in your testimony on doing something now about the problems that we have discovered—to streamline and devise more efficient procedures—is good.

I would like to comment once again on this committee's oversight responsibilities. The Aging Committee has always been looked upon as an advocate for the elderly, and we have fulfilled admirably that responsibility. The new emphasis you have placed upon improving the efficiency of the expenditure of those funds, getting more bang for the buck, in a sense, has been one of the best things that we can do to strengthen the support we provide to the elderly. You have to administer these programs efficiently and effectively. And in the end, it is in the best interest of all of us.

The Illinois audit identified major problems in Federal policy and auditing procedures. Have these findings been transmitted to the Health Care Financing Administration, and if so, what was their reaction?

Mr. MITCHELL. They have not been transmitted, Senator Percy, because the Health Care Financing Administration was a party to the report. They are in the hands of the administrator at this time and are being reviewed by her staff. I might point out that the study team that did this study is meeting on Friday in Chicago, with the intermediary there, to consider comments that the intermediary has put together.

Senator PERCY. In the Illinois audit report on page 32, a figure of $66,799 is cited as the estimated savings if certain material errors were corrected. Could you briefly explain what these errors were, how they were made, and if this kind of error, in your experience, is frequently made.

Mr. MITCHELL. That is the $666,000 number, sir?

Senator PERCY. Yes, $666,000 as the estimated savings. How were those errors made?

Mr. MITCHELL. They are made generally, Senator, because people simply do not keep the records that are necessary to allocate the time and effort of physicians and other people in the hospital. I believe these are mostly physician time. Teaching hospitals would be a good example, or any hospital where a physician who is a salaried physician and who also treats private patients, would be another example. The time that a salaried physician is treating private patients, should not be charged to the medicare and medicaid programs. Many times, the physician's entire time is charged off to the program. By and large, it is just a question of requiring very sophisticated and very complex recordkeeping mechanisms to keep track of the physician's time all the time he is in the hospital. This is a very, very difficult problem, but one under our present system that we require.

Senator PERCY. Now, the report makes many recommendations, including a series on audit procedures which generally require the intermediary to spend more time overseeing providers. Could you briefly explain what auditing procedures intermediaries are now required to conduct that they are not actually conducting, and also, what new procedures you think should be instituted by them.

Mr. MITCHELL. When the medicare program was in its initial stages, Senator, the intermediaries conducted what are really audits—that is, going into a provider's office or into a hospital, actually looking at records, and going behind records, if you will. Today, because the Government has reduced considerably the amount of money available to the intermediaries to conduct audits, the intermediary audits are more desk reviews than they are true audits, relying on the reports made by the providers to them. In my view, they barely qualify for the term, "audit." And when I say this, I am not lambasting the intermediaries, because they can only provide the amount of audits that we authorize them to provide.

Senator PERCY. What does HCFA do, assuming there is no audit conducted by the intermediary?

Mr. MITCHELL. HCFA has several things, Senator. They have what they call a validation process, which is kind of a spot audit process. They also have an evaluation system for the intermediaries. But once again, you cannot require the intermediaries to do something that they are not paid to do.

Senator COHEN. If I could just follow up, Senator Percy.

Senator PERCY. Yes, certainly.

Senator COHEN. What you have is a situation in which you have a very complex cost reimbursement system which is so complex, it becomes exasperating. This exasperation, in turn, leads to essentially indifference. I can go through the home health care hearings we had, in which we had essentially the same facts before us. You have got the scheme of the Federal dollars starting at the Federal Treasury, and it flows through the whole system. There is no check by the intermediaries. They do not have the money coming from the Federal Government, therefore, they do routine stamps of approval of every bill coming back through. They send it back through HCFA, HCFA does not have the resources and is not conducting audits, other than periodic checks. So what you have is a nice circle, in which it all comes back to the Federal Treasury, and nobody—nobody—is exercising oversight. Isn't that essentially what you have got in our health care system?

I can go back and point to Dr. Kones, who testified here about defrauding the Government of millions of dollars—he said he had to so overstate his bills as to deliberately be caught. He billed this country hundreds of thousands, if not millions of dollars, totaling up over the years, and he said it was outrageous. The bills had to be so excessive that anybody would have caught it, and nobody caught it, only because it was so outrageously excessive did somebody finally catch him, because he wanted to be caught, according to his own psychological state at that point.

But it seems to me, as we go through this hearing—and Senator Percy has been a leader on this committee for a long, long time—the fact of the matter is that we have virtually no oversight, no checks, no supervision, few audits, and the money keeps pouring out.

Mr. MITCHELL. I would agree with what you have said, Senator, except for the fact that I do not believe the doctor wanted to get caught.

Senator COHEN. Well, he sure did his best.

Senator HEINZ. Well, now that he is going to do 7 years, maybe you are totally right.

Mr. MITCHELL. I think part of the complexity, Senator, is that we spent something like 1,200 hours of investigative time working on the good doctor's case. That is just one provider: 1,200 hours.

Senator PERCY. I think it is a good investment. At 1,200 hours, you will get a high return on investment on that time.

Is there any way to assess the cost to the Federal Government of instituting the additional oversight requirements by the intermediaries, and do you have any estimate of how much these measures would cost in, say, Illinois, and then in the country? If you do not have those figures now, you may supply them for the record.

Mr. MITCHELL. We have some figures, Senator, but I do not have them with me. We will provide them for the record.

Senator PERCY. All right, fine. We will keep the record open for those.

[Subsequent to the hearing, Mr. Mitchell supplied the following information:]

The Illinois hospital audit project involved direct audit of hospitals rather than of the intermediary audit process. Inadequacies in the intermediary process were inferred from inadequacies found in providers. It is, therefore, not possible to provide an estimate of increased intermediary costs based on this project.

However, as was noted in the project report, one consistent problem uncovered by the project was the fact that intermediary audit time was being spent in reconstructing hospital records rather than in auditing those records. The maintenance of auditable records is a provider responsibility and the assumption of this responsibility by providers would enable the intermediary to enhance its proper audit function without a net increase in either time or cost.

Furthermore, there is every reason to believe that the performance of additional oversight by the intermediary will result in net savings rather than costs to the

Government. This is because statistics available indicate a savings of as much as $7 in program costs for every dollar spent on intermediary audits.

Because of this net benefit to the Government from intermediary audits, the OIG is seriously concerned at the actual constriction in intermediary audit dollars being planned for the next fiscal year. We have conveyed our concern to the Health Care Financing Administration and are planning to pursue this issue.

Senator PERCY. Finally, the audit report cites three assumptions of savings which I mentioned in my opening remarks. That is, if proper enforcement of regulations were to result in a disallowance of even 10 percent of the amount paid to hospital-based physicians, there would be a program savings of $16.5 million. Is this 10-percent figure and other percentage savings estimates realistic? Can we save that much if we institute the recommendations in this report, and what would the nationwide implications be? Do you have any figures on possible nationwide savings?

Mr. MITCHELL. For the report as a whole, Senator, if we can validly project from the 34 hospitals in Illinois, we would estimate that the programs could save $500 million.

Senator PERCY. We will keep the record open for all of the other statements.

I want to thank the witnesses very much, indeed.

I am delighted to have Senator Cohen join us, who also has served in the Governmental Affairs Committee and helped institute the Inspectors General, and we are expecting the Inspectors General to do an awful lot of the work that is oversight that normally was deferred to us. We think you can catch it a lot sooner. There is a tremendous amount to be done in this area.

Thank you.

Senator HEINZ. I have a couple of brief questions, and then I will be happy to turn it over to Senator Cohen, and then we are going to hear from Barry Friedman.

Let me just ask you what I guess is the bottom line question from the standpoint of medicare. Do you believe that the current reasonable cost reimbursement system is salvageable and if so, what must be done to make it work? If not, what would you propose?

Mr. MITCHELL. Let me speak for myself, Mr. Chairman, and disassociate the administration from my remarks. In my personal opinion, it is not salvageable.

Senator HEINZ. It is not?

Mr. MITCHELL. It is not. It must be changed. It is simply too complex, too complicated, and the volume that moves through it is just too large. I know that it is extremely easy to beat intermediaries and carriers about the head and shoulders, and the State people who run medicaid reimbursement systems, but if you ever spend any time in their operations and see the literally millions and millions of pieces of paper that flow through there—pieces of paper that have procedure codes, big, long lists of procedure codes—it is incredible. And as all of this gets bigger and bigger because of more and more people being covered under these things, it just seems to me that there is no way that you will ever make it efficient and effective. Now, you can improve it, but in terms of really doing what I think should be done, I do not believe you can do it.

Senator Heinz. Thank you, Mr. Mitchell. I have some questions I will submit for the record.

[Subsequent to the hearing, Senator Heinz submitted questions to the Office of Inspector General, Department of Health and Human Services. Those questions and responses follow:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
OFFICE OF INSPECTOR GENERAL,
Washington, D.C., April 29, 1982.

Hon. JOHN HEINZ,
Chairman, Special Committee on Aging, U.S. Senate, Washington, D.C.
(Attention of David Holton).

DEAR MR. CHAIRMAN: Please find enclosed our responses to those questions still outstanding from your hearings on the Office of Inspector General and the hospital reimbursement system. We have included appropriate enclosures for inclusion with the record.

If I can be of any further service to you, please do not hesitate to contact Stephen Davis of my staff at 472-3480.

Sincerely yours,

RICHARD P. KUSSEROW,
Inspector General.

Enclosures.

QUESTIONS FOR BRYAN MITCHELL, ACTING DEPUTY INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Question 1. The committee found in December that less than 10 percent of the resources available in the Department to combat fraud, waste, and abuse were under the Inspector General's control. Is that still the case?

Answer. As you know, this Department is committed totally to reducing fraud, waste, and abuse among its programs. The Department's focal point for this effort is the Office of Inspector General (OIG). The jurisdiction of OIG auditors and investigators is departmentwide. Other components such as the Social Security Administration (SSA) and the Health Care Financing Administration (HCFA) contain resources which specialize in combating waste, fraud, and abuse for their respective operating divisions. OIG staff cooperate closely with these other components. Consequently, although actual staff allocations to the OIG may approximate 10 percent, it is difficult to state accurately the extent of departmental resources attributed to combating fraud, waste, and abuse.

Question 2. What were the total number of medicare and medicaid fraud convictions for 1981, generated by the Inspector General, State medicaid fraud control units, FBI, and others?

Answer. During 1981, the Office of Inspector General, Department of Health and Human Services was responsible for 47 medicare and medicaid fraud convictions. The State medicaid fraud control units were responsible for another 237. We do not have information on convictions by the FBI or others.

Question 3. What were the total number of fraud convictions by the State medicaid fraud control units (SMFCU). Please specify by State.

Answer. Listed below are SMFCU convictions by calendar year 1981:

Alabama	1	Montana	2
Arkansas	0	New Jersey	12
California	8	New York	86
Colorado	1	North Carolina	7
Connecticut	5	Ohio	5
Delaware	4	Pennsylvania	12
District of Columbia	0	Rhode Island	6
Florida	0	Texas	3
Hawaii	2	Utah	1
Illinois	7	Vermont	3
Kentucky	0	Washington	3
Louisiana	8	West Virginia	1
Maine	3	Wisconsin	10
Maryland	13	Total	237
Massachusetts	16		
Michigan	18		

QUESTIONS PREVIOUSLY ADDRESSED TO MR. KUSSEROW

Question 1. Given the size of the problem and available resources, what priorities have you established for your Office? How will resources be targeted?

Answer. We have just completed an extensive work planning process in order to aline our resources in the most effective manner. I am attaching a copy of the executive summary which outlines our new priorities. (Enclosure—work plan from 1982 Inspector General report to Congress not reprinted.)

Question 2. You indicated in your testimony an intent to reorganize the Office of Inspector General. How do you envision the Office functioning? Will your reorganization affect all three of the Office's principal components or just the Audit Division? When is it anticipated the reorganization will be completed? Please include with your description your rationale for the changes to be made?

Answer. We are in the process of a reorganization of the entire OIG office. This reorganization will be fully implemented May 1, 1982. There are several objectives we hope to achieve by the proposed reorganization. In many ways, this reorganization reflects our priorities and as how we plan to meet these priorities with our existing resources. The more significant objectives are as follows:

(a) Conform the internal organizational structure of the Office of Auditing (OA), Office of Investigations (OI), and the Office of Systems Integrity (OSI) to the organizational structures which carry out the principal functions of the Department.

The organizational structure of the Department has changed substantially over the years. However, the internal structure of the HEW Audit Agency (OA) has not been significantly altered to reflect those changes since it was established in 1965. Similarly, the Office of Investigations (OI) has never been reorganized to clearly parallel the Department's structure. Furthermore, although the roles of both OA and OI have gradually grown, their structures do not reflect that growth and new direction. Under the new structure, OA is now responsible for reviewing the design of and auditing computer-based systems, and OI will add civil money penalty and administrative sanctions emphasis to its existing criminal investigatory function.

Under the reorganization OA, OI, and OSI will each have units devoted specifically to: (1) Social security; (2) health care financing; and (3) grants and internal systems which will cover the Public Health Service, Human Development Services programs and procurement. In addition, OA will now have a Division of Automated Data Processing (ADP) Audits in order to conform to both the General Accounting Office (GAO) and Office of Management and Budget (OMB) requirement that we develop the capability to audit computer-based systems. OI, will have a new Division of Civil Fraud which will focus on both debarment and suspension as well as on investigating civil fraud cases. Not only will this approach harmonize better with the organization of the Department and with the principal functional responsibilities of the OIG offices, but it should foster greater cooperation and more joint projects among OIG staff offices—a major management objective of this Inspector General.

(b) Streamline the organization of the Immediate Office of Inspector General to improve the flow of information problems as they arise and to expedite the decision-making process. In conjunction with changes in the Immediate Office, I will eliminate the Office of Executive Assistant Inspector General, which has become a catch-all for a variety of unrelated responsibilities.

Since its inception, the OIG has become an increasingly visible and active component of the Department. As the OIG has become more integrated with the Department and the executive branch, the Executive Assistant Inspector General (EAIG) has assumed a broader, although not necessarily related, array of responsibilities. For example, staff within the EAIG had become responsible for budget, personnel, liaison with OMB and the President's Council on Integrity and Efficiency, and other crosscutting projects.

Under the reorganization plan, those functions that are truly administrative (e.g., budget and personnel) will be performed by an Administrative Office, reporting to the Deputy Inspector General. Other individuals, also reporting to the Deputy Inspector General, will be responsible for legislative liaison, planning and coordination, and advising on health issues. The executive secretariat will report to the Inspector General through my confidential assistant. This approach should make the Inspector General more accessible to individuals in key staff positions and improve the flow of information.

(c) Improve management by monitoring the Department's performance in regard to taking administrative action in response to misconduct by Department employees, grantees, contractors, and other program participants.

The current assignment of decisionmaking responsibilities within the Department for matters such as adverse personnel actions, debarment of grantees or contractors, and suspension of health care providers will remain unchanged. However, OIG cases in which administrative action is appropriate will be referred to the responsible office and monitored by the OIG through the new Civil Fraud Division of OI. These procedures should enable better coordination among OPDIV's and STAFFDIV's and should improve the Department's followthrough in these cases.

(d) Substantially increase OIG responsibility for controlling civil fraud and other noncriminal wrongdoing.

The Office of Investigations (OI) was in existence prior to enactment of the law which required the establishment of the OIG. At the time, its investigations were limited to criminal wrongdoing, primarily by Department employees. Since OI became a part of the OIG, it has expanded its activities to cover all HHS program areas, but the focus has remained strictly criminal. However, the OIG statute requires the Inspector General to assume responsibility for fraud, abuse, waste, and mismanagement—suggesting a broad investigatory role, not limited to criminal wrongdoing.

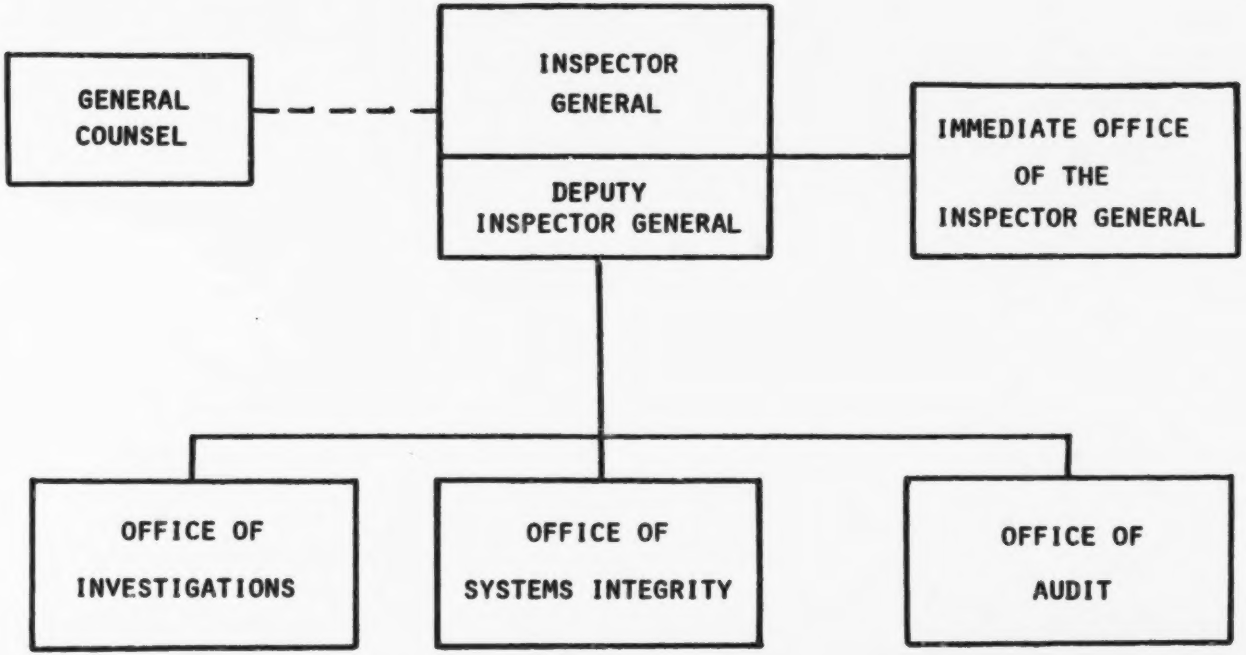
Under the reorganization plan, OI will include, for the first time, a Civil Fraud division to: (1) Coordinate and supervise noncriminal investigations by OI agents; (2) coordinate and supervise investigations that will lead to imposition of administrative fines under the so-called civil money penalty legislation contained in the Omnibus Reconciliation Act of 1981, and to greater reliance on the False Claims Act to recover funds and deter fraud; (3) investigate or supervise investigations of standards of conduct violations by Department employees; and (4) supervise the "Hotline Complaint" unit.

I have attached a diagram of the revised OIG organization for the record.

Attachments.

OFFICE OF THE INSPECTOR GENERAL

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES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DEPUTY INSPECTOR GENERAL
GENERAL COUNSEL
IMMEDIATE OFFICE OF THE INSPECTOR GENERAL
OFFICE OF INVESTIGATIONS
OFFICE OF SYSTEMS INTEGRITY
OFFICE OF AUDIT

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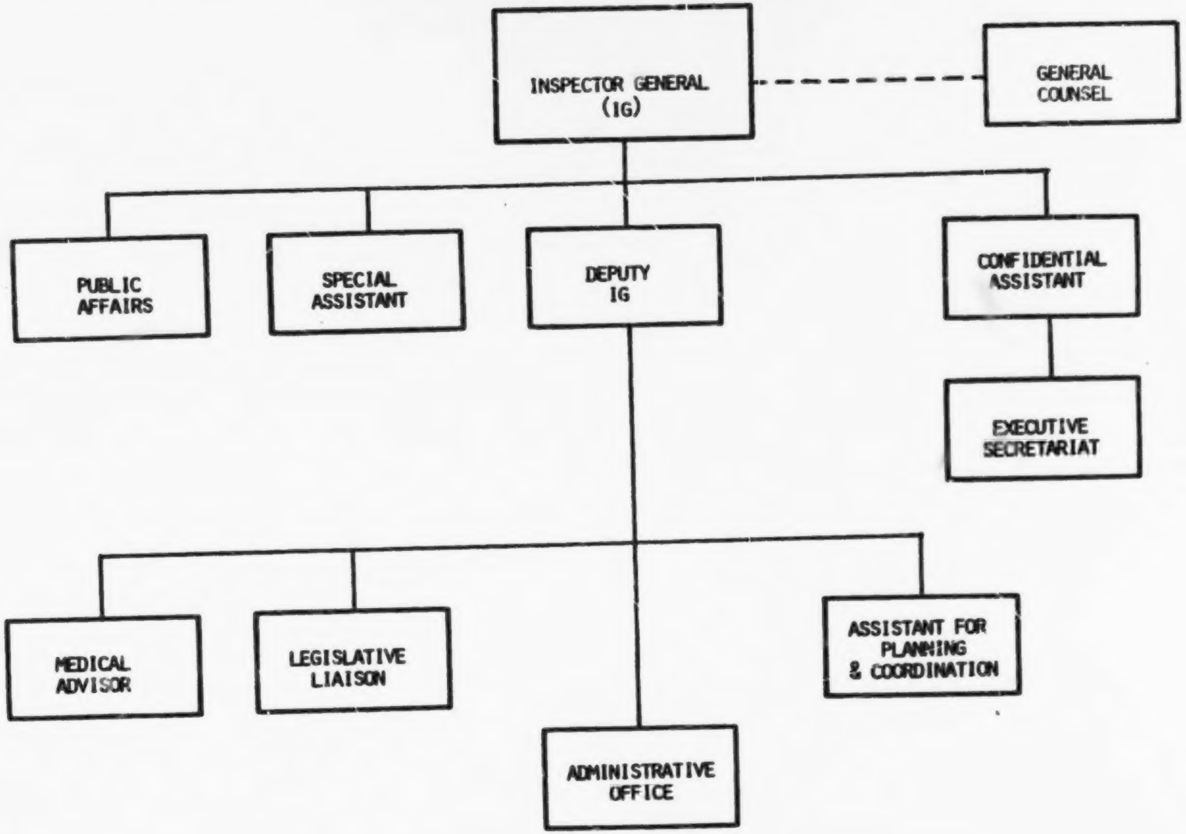
IMMEDIATE OFFICE OF THE INSPECTOR GENERAL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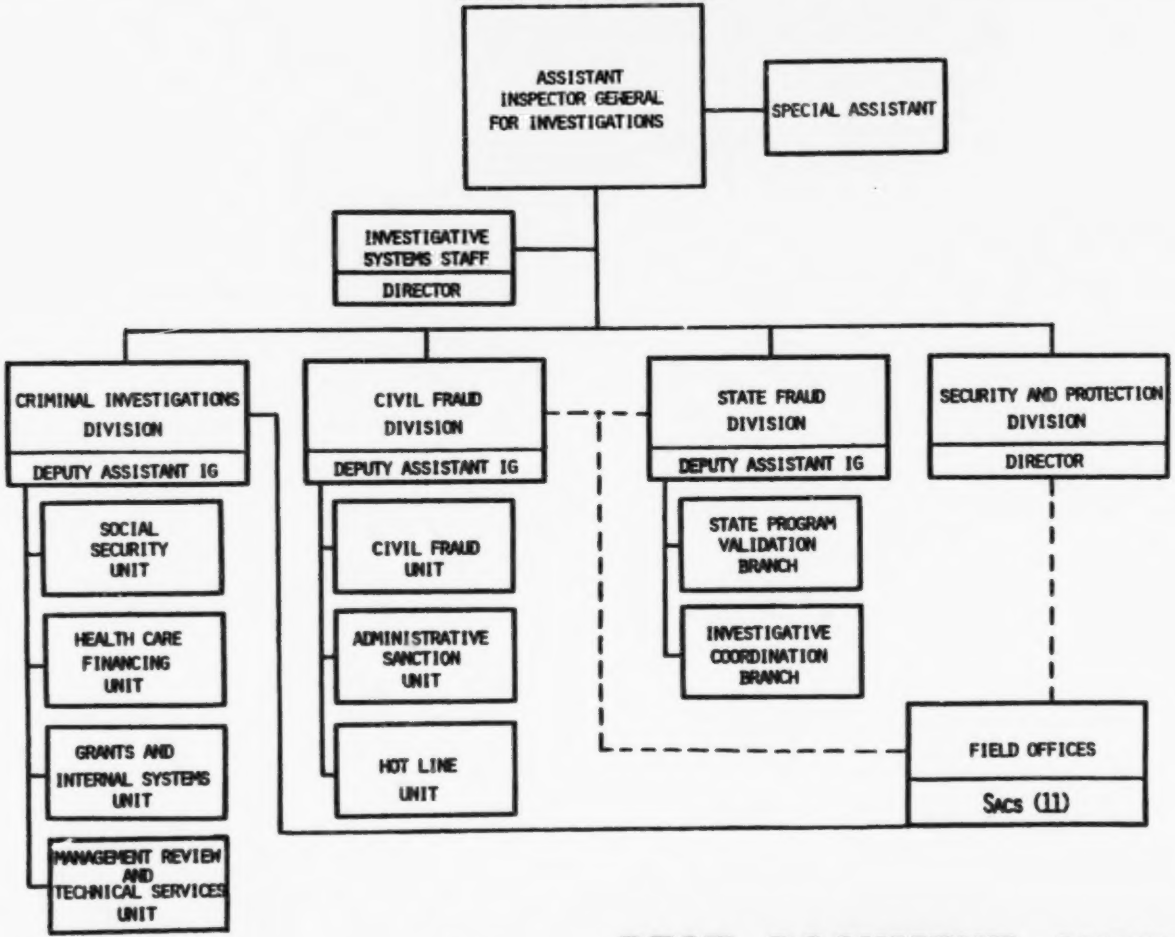
GENERAL COUNSEL
PUBLIC AFFAIRS
SPECIAL ASSISTANT
DEPUTY IG
CONFIDENTIAL ASSISTANT
EXECUTIVE SECRETARIAT
MEDICAL ADVISOR
LEGISLATIVE LIAISON
ASSISTANT FOR PLANNING & COORDINATION
ADMINISTRATIVE OFFICE

OFFICE OF INVESTIGATIONS


ASSISTANT INSPECTOR GENERAL FOR INVESTIGATIONS
SPECIAL ASSISTANT
INVESTIGATIVE SYSTEMS STAFF
DIRECTOR
CRIMINAL INVESTIGATIONS DIVISION
DEPUTY ASSISTANT IG
CIVIL FRAUD DIVISION
DEPUTY ASSISTANT IG
STATE FRAUD DIVISION
DEPUTY ASSISTANT IG
SECURITY AND PROTECTION DIVISION
DIRECTOR
SOCIAL SECURITY UNIT
HEALTH CARE FINANCING UNIT
GRANTS AND INTERNAL SYSTEMS UNIT
MANAGEMENT REVIEW AND TECHNICAL SERVICES UNIT
CIVIL FRAUD UNIT
ADMINISTRATIVE SANCTION UNIT
HOT LINE UNIT
STATE PROGRAM VALIDATION BRANCH
INVESTIGATIVE COORDINATION BRANCH
FIELD OFFICES
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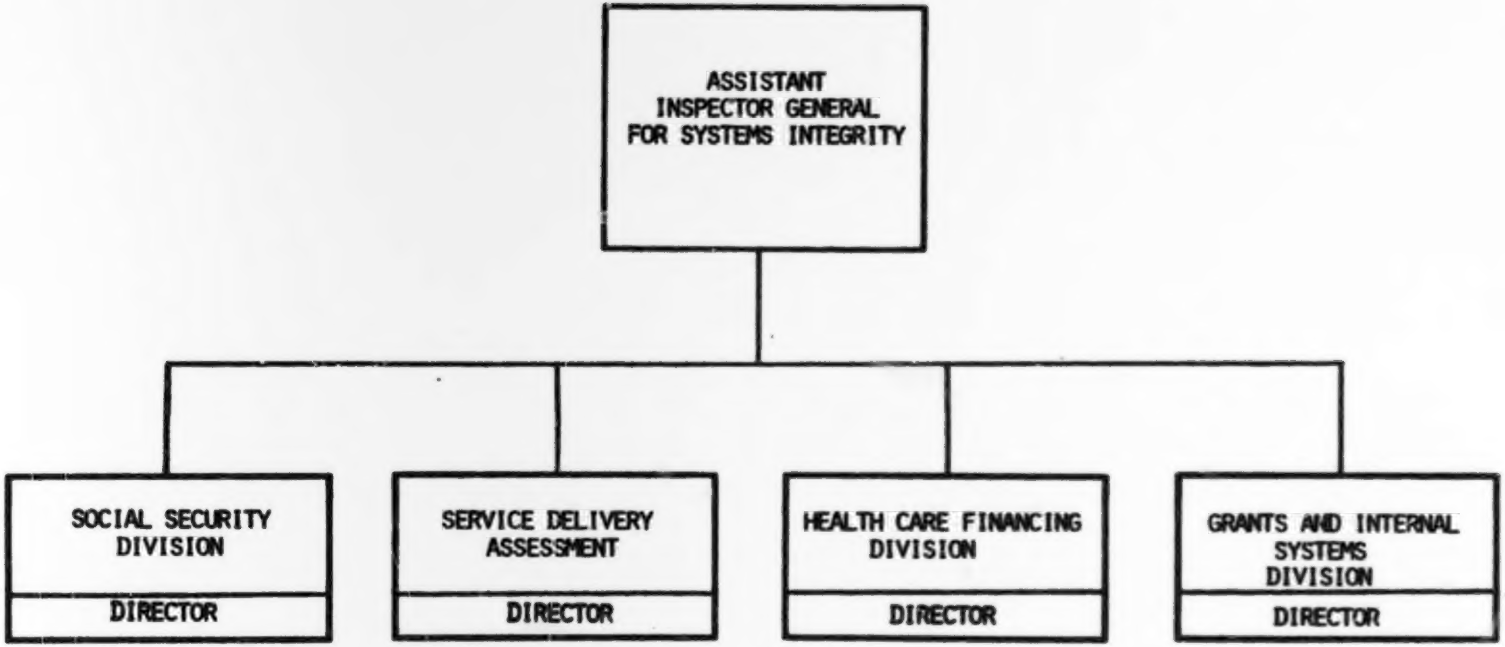
OFFICE OF SYSTEMS INTEGRITY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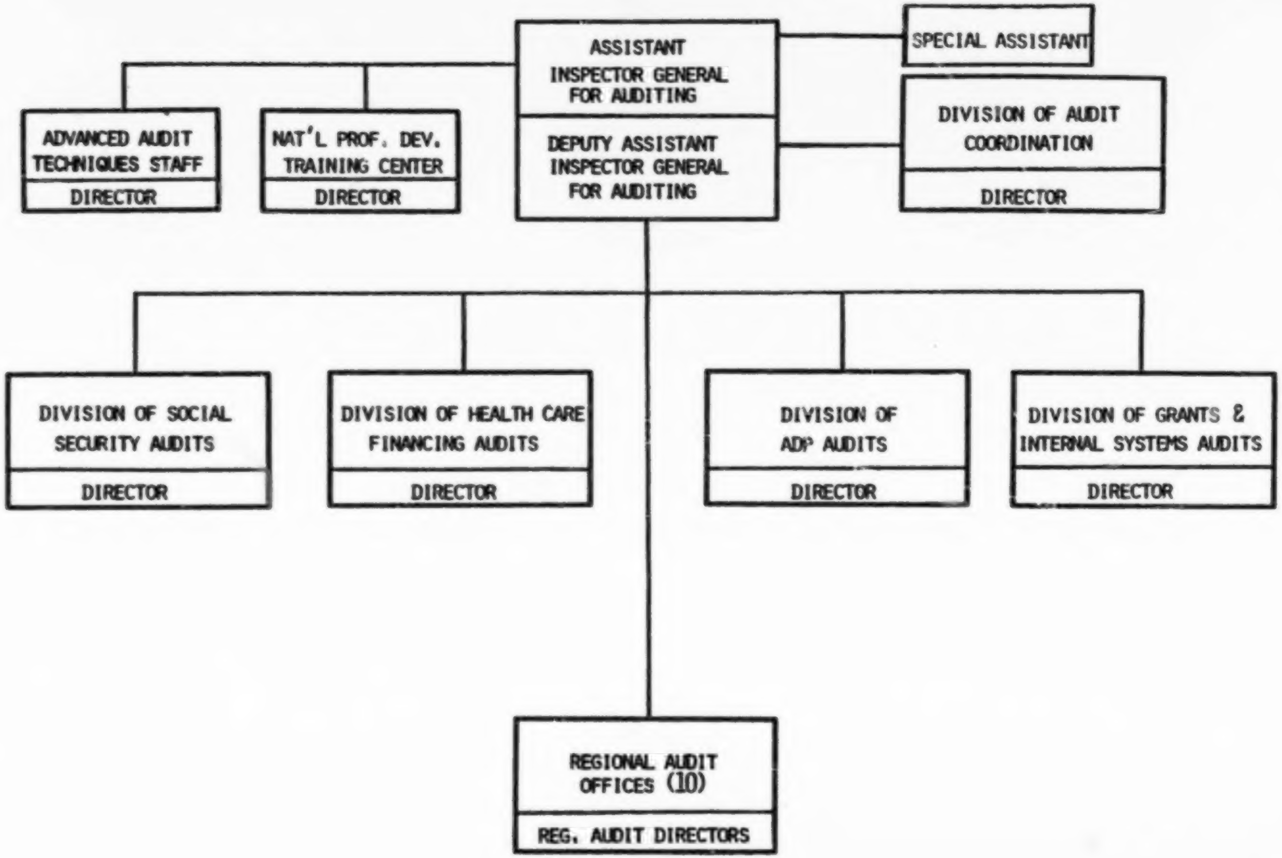
SOCIAL SECURITY DIVISION
DIRECTOR
SERVICE DELIVERY ASSESSMENT
DIRECTOR
HEALTH CARE FINANCING DIVISION
DIRECTOR
GRANTS AND INTERNAL SYSTEMS DIVISION
DIRECTOR

OFFICE OF AUDIT


ASSISTANT INSPECTOR GENERAL FOR AUDITING
DEPUTY ASSISTANT INSPECTOR GENERAL FOR AUDITING
SPECIAL ASSISTANT
DIVISION OF AUDIT COORDINATION
DIRECTOR
ADVANCED AUDIT TECHNIQUES STAFF
DIRECTOR
NAT'L PROF. DEV. TRAINING CENTER
DIRECTOR
DIVISION OF SOCIAL SECURITY AUDITS
DIRECTOR
DIVISION OF HEALTH CARE FINANCING AUDITS
DIRECTOR
DIVISION OF ADP AUDITS
DIRECTOR
DIVISION OF GRANTS & INTERNAL SYSTEMS AUDITS
DIRECTOR
REGIONAL AUDIT OFFICES (10)
REG. AUDIT DIRECTORS

Senator HEINZ. Senator Cohen, do you have some questions?

Senator COHEN. One observation. I noted on page 9 of your statement that you look like you are paraphrasing Dr. Johnson about the time he was walking down the street with a lady friend, and they saw that dog walking on its hind legs, and she said, "How grotesque." He responded, "The notable thing, ma'am, is not that it is grotesque, but that he does it at all." And I note that you have come to that same conclusion about our system, that the notable thing is not that we do it so poorly, but that it functions at all.

What I gather from what you have just said to Senator Heinz is that we are not even doing it at all in some instances. I would have to agree with what you have just said, that the system is so complex and there are such time constraints on trying to bring service to people, to help them, to save their lives in many instances, that we are just throwing our hands up in exasperation. It becomes one long assembly line of people just sort of stamping approval and not having the time or taking the time, or not being concerned, about being caught with excessive charges.

I have said this on so many occasions, but what strikes me about all the investigations that are held either by the Senate Aging Committee or the Permanent Subcommittee on Investigations, is that there seems to be a common theme throughout. That is, there is very little risk of detection, there is little risk of prosecution, there is little risk of being convicted, and even if one is convicted, there is little risk of being incarcerated. You can see why we have problems in almost every facet of our society, because somehow, we have gotten so busy, we have gotten so complex, that we are simply unable to cope with this informational overload, and therefore, we keep paying the bills. That is why you see such a dramatic increase in the cost of everything.

Senator Percy has left now, but it happened with our "chop shops" hearing. He chaired hearings revealing an industry—I think it was close to a $50 billion industry—is being developed by people who steal cars. Within hours, they chop them up. A good torch and acetylene man can make about $200,000 a year, tax-free. And what do we do? Well, the car is stolen. You go to the insurance company, the insurance company pays the bill, and then increases the premiums of everybody else, and passes the cost on to all Americans. What you have is the socialization of crime. Nobody really cares, because after all, somebody else is paying for it. The insurance company is taking care of it, and then the taxpayers are taking care of it, because they are paying higher premiums, and it just goes on. But there's no real concern.

Senator HEINZ. Senator Cohen, earlier when we were being briefed on the Community Hospital of the Valleys, some people might have described it as a "chop shop," too.

Senator COHEN. Well, since I was not here to hear that, I will pass on that observation. But the point is that there is no incentive because there is no penalty. There is no notion that somebody is looking over our shoulder who is going to detect all this or is concerned about it.

And I have seen it—and I hold up this home health care fraud and abuse study—it is extraordinary the similarities in this case and the one that is before us today. I agree with your conclusion, we have got to follow the advice of clearing the clutter out of our lives and simplifying the process. How do we do that? I suppose we are looking to you for direction as to how to simplify this system so it is fairly uniform, so that it can be quickly discernible if it is excessive, and so that that fear of detection will have a salutary impact, namely, that people will be more responsible when submitting bills.

But absent that, if we continue to go the way we are going, we are simply going to find that health costs, which are 9 percent of the gross national product right now, will probably be a good deal more as costs continue to escalate at 18 percent a year. That is the rate that the hospital costs are going up. That is all I have, Mr. Chairman.

Senator HEINZ. Senator Cohen, thank you. As a matter of fact, I am really not being facetious when I take your discussion of the "chop shop." When this kind of system is taken to its extreme as some very unscrupulous people have done, we run the risk of turning what most people believe is a very excellent health care system and a very excellent hospital-based system of delivery into "chop shops." And I do not say that just in terms of the medical services provided, but I say that with respect to the quality of care provided, the shortcuts that would be taken both to obtain the maximum amount of reimbursement and in delivering the least amount of health care. That is what the system tends to encourage. In some respects, it speaks well for many health care providers that in spite of the system, the quality of care is as high as it is. We know for every bad example, there are many good ones. Some of the testimony we will have later will reveal this. But each year, the recoveries from the intermediary Inspector General, and others, keep going up. Once upon a time, you got $5 for every dollar's worth of investigation you did. I think you will hear that it is now $26 to $1. We will also hear that in one State it is $76 to $1. What is different? What is different is, as time moves on, recoveries are increasing—why? Not only because the amount of money involved is increasing, but because the abuses of the system are increasing. When you go from 5 to 26 to 75, that is not what they call a straight line progression. That is a geometric progression. People are catching on and catching on fast. That is a learning curve. [Laughter.]

The staff will come to order, please.

That is indeed a serious sign, and I think you have really hit the nail on the head.

May I ask Mr. Friedman to proceed?

STATEMENT OF BARRY FRIEDMAN, NEW YORK, N.Y., CHIEF ASSISTANT DEPUTY ATTORNEY GENERAL, MEDICAID FRAUD CONTROL UNIT, STATE OF NEW YORK

Mr. FRIEDMAN. Thank you, Chairman Heinz, and members of the committee.

I am appearing before you today on behalf of Edward J. Kuriansky, deputy attorney general in charge of New York's medicaid fraud control unit. I am the chief assistant to Mr. Kuriansky, and prior to that, I was in charge of the hospital project conducted by our office.

Seated behind me in the audience are Warren Donovan, our chief investigator, and Michael Jaeger, our deputy chief auditor.

We are very pleased to again appear before this committee. In the past, you have contributed very significantly to not only the important battle against fraud and abuse in the health care industry, but also the battle for improved quality of health care for our citizens. We are grateful for this assistance and, in turn, would like to be of some assistance to you today.

By way of a brief history of our office as it relates to today's hearings, in 1977, the then HEW awarded our office a 2-year Federal contract to investigate and prosecute fraud and abuse in the New York hospital industry, pursuant to a model investigative program that we devised.

Our goals were essentially twofold; that is, to assemble a significant body of factual data on the degree and types of fraud and abuse in the hospital industry, utilizing research, investigation, and prosecution; and to develop fraud audit and fraud investigation training manuals and programs which were based upon our actual experiences.

The contract required us to perform 25 limited and 25 full-scope audit investigations of hospitals located throughout New York State, including audits of facilities of various types of ownership or sponsorship. In New York, the types of facility ownership consisted of propriety, voluntary, community, and governmental hospitals, whereas chain types of ownership that are found throughout the country are not permitted.

We conducted representative audit investigations in each type of facility around the State. Additionally, the audit and investigative manuals have been distributed throughout the country to other medicaid fraud control units, to single State agencies, and to other law enforcement agencies such as the Federal Bureau of Investigation. A copy of these manuals, Mr. Chairman, has been submitted along with our testimony, for the committee's information.[1] In all honesty and in all modesty, these manuals are considered the state of the art in white-collar fraud audit investigation and we have found that they are standard reading throughout the Nation.

Our 2-year contract with HEW was renewed for an additional year, with a more specific set of deliverables that were based upon our experiences during the first 2 years. During the third year, we conducted a nationwide training program in the area of hospital audit investigations. As Mr. Mitchell said, we gave four 1-week regional training courses throughout the Nation. Additionally, we took an in-depth look at certain types of findings that we had picked up repeatedly during the previous 2 years of our contract, to determine just how widespread some of these practices had become. Additionally, we had an opportunity to explore other areas in the New York system that we could not adequately explore during the 2-year hospital contract period. It is from this background that we now turn to address the specific concerns of this committee.

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[1] Retained in committee files.

Our audit investigative experience was, of course, directed at the medicaid program in New York, but since the principles of medicare and medicaid are so intertwined, we feel that our experience should be of some direct interest to the members of this committee.

At the outset, we must state that given our data base, we cannot and we will not quantify the extent of fraud and abuse in the hospital industry. What we can do today is to tell this committee about the types of frauds that we have discovered; about existing accounting manipulations that are virtually unauditable and yet have dramatic impact on reimbursement; about kickbacks and vendor fraud that run rampant through the industry, without apparent regard to the types of product being sold; and about the problems of verifying hospital costs.

We have had significant findings and experiences in the following areas.

First, is coordination of benefits. It is not improper and certainly quite understandable that a hospital will bill more than one payor for a patient's hospital stay, since the hospital may be uncertain at the time of the billing of the patient's various eligibilities.

Senator **Cohen**. Do you mean by that that they would bill Blue Cross/Blue Shield plus the——

Mr. **Friedman**. Medicare and medicaid, yes, Senator.

Senator **Cohen**. They just do not make refunds when they all come in.

Mr. **Friedman**. That was my next sentence. What is obviously improper is for the hospital to fail to refund overpayments to the proper parties and to eventually keep these moneys which are in excess of the patient's balance. We have found this type of improper retention to be quite out-of-hand in the hospital industry, and in New York, we have devised a system and made a major effort to verify this type of conduct in a way that we feel assures its ultimate disappearance.

Our second area is infant billings. Different per diem rates apply in New York for infants, depending on whether a newborn is being treated as routine or is in need of some special care, such as a premature baby would require. We have found that in many cases, where a baby's stay began as premature, but later became routine during the hospital stay, that the entire stay was billed to the system as premature. This type of billing procedure, we have found, has become almost an institutionalized practice in New York. Although it has little medicare application, it illustrates the fact that certain fraudulent and abusive practices have almost become written in stone in the hospital industry.

Third, is staff physician private practice. We have found that certain hospitals, in an attempt to increase the hospital's prestige and even its profitability, will attract physicians by providing them with "sweetheart" arrangements concerning their private practice privileges, without regard to the increased costs to the programs. The physicians are permitted to practice at the facility and are generally assigned staff such as nurses, secretaries, and billing clerks. These employees are later included in cost reports that the hospitals are filing, as though these support personnel are hospital employees when, in fact, they are really only supporting the private practice of the physician.

Additionally, these same hospitals provide laboratory services, space, and utilities free of charge to the physicians. Applicable regulations require that expenses associated with private practice, both direct and indirect, be reduced from hospital cost reports, but we find that all too frequently, this step has been omitted.

Fourth, is cost allocation. In many situations, it is necessary for a hospital to estimate statistics that ultimately affect cost allocations to various hospital services. Because it would be impractical for a hospital to keep all of the statistical data needed, estimates have become a generally accepted accounting practice. These estimates are usually based on a "statistical study" done by the hospital's fiscal department. Strangely, the result that one notices is that the hospital-generated estimates always seem to back up findings that insure maximum reimbursement for the hospital.

For instance, we find that if a hospital outpatient per diem rate has been "capped out" for various reasons, that these "studies" seem to allocate much greater costs into the inpatient or emergency room service than would seem possible. Conversely, where the inpatient per diem rate has reached the maximum, these studies tend to allocate more to outpatient and emergency services than would seem reasonable.

We can safely say that abuses, and sometimes outright frauds, that are associated with accounting manipulations cost the programs many millions of dollars a year and at the same time, are not properly audited under the existing methodologies now in place in this country. To detect and eliminate the types of manipulations being mentioned here would require, in our opinion and in our estimate, a tripling of amounts now being spent for auditing the facilities by Government intermediaries.

Senator **Cohen**. What if you just put a cap on the outpatient and emergency services? I mean, what you are describing is squeezing a balloon from the middle.

Mr. **Friedman**. Well, yes; I am describing a situation where one of the services is not being capped.

Senator **Cohen**. That is right. So, if you squeeze it, it is like water or air going to a different level.

Mr. **Friedman**. There are occasions where you will find, in a facility that is most abusive, that all of the services will be capped, and that situation speaks for itself.

Our last broad example is vendor kickback and employee theft. These two areas represent massive problems to a cost-based reimbursement system. The committee can be assured that these kickbacks and thefts are ultimately passed along to the programs and the taxpayers. Most purchases in hospitals are highly profitable to the vendor, either because of the high volume involved, or the expense of the product. Thus, there is room for kickbacks, which can easily be arranged behind closed doors.

I will now briefly list for the committee additional findings which we have uncovered and which time constraints prevent a more detailed discussion today.

No. 6, is intentional or mistaken overbilling of patient days; No. 7, is understatement of patient days for statistical purposes; No. 8, is improper billing of elective cosmetic surgery as medically necessary surgery; No. 9, is failure to offset income against related expenses; No. 10, is padded payrolls; No. 11, is inflated and fictitious invoices; No. 12, is personal expenses being charged to the hospital and ultimately included in cost reports; No. 13, is bid rigging, and undisclosed relationships; No. 14, is physician billing for services already included in the reimbursement rate; and No. 15, is service patients being billed as private patients, and this is a tremendous problem—not that the others are not.

I do not intend that this list be viewed as an all-inclusive statement of our experiences in the hospital industry or the experience of other units nationwide.

Essentially, our experience has been that whatever schemes one could conceive of, have, in fact, been proven to exist. We have essentially audited and investigated 75 of the 380 hospitals in New York State and have had significant criminal and/or civil findings in about one-half. We have recovered almost $7 million from hospitals and have had some individual cases that have reached over $1 million apiece. We have had findings in facilities regardless of ownership or not-for-profit status.

Certain generalities can, of course, be drawn. We have had more criminal findings in urban and suburban areas than we have had in the more rural settings. In suburban hospitals there seem to be more employee theft and kickback arrangements than we have found in urban and rural areas; the types of crimes found in voluntary hospitals differ from those found in proprietaries is that they are more sophisticated, mirroring the makeup of the facility with large fiscal staffs and yet at the same time, less motive to steal outright as an institution, being a not-for-profit organization. Thus, we have found the more esoteric audit frauds and abuses in voluntary hospitals, and the more obvious crimes in the proprietary hospitals.

Despite all of the above, we do not find ourselves, again, in any position to quantify and qualify the degree of fraud and abuse in the hospital industry. Certainly, it is there to the tune of at least many, many millions of dollars in increased cost to the program per year that could be better used for improved patient care, or in this time of budgetary constraints, as a reduction of program costs to governments.

It is clear that the intermediary audit programs have not performed the function that they were designed to perform in that they are certainly not adequately safeguarding the public funds in New York. We suspect that this has become a nationwide problem, but we cannot as yet draw that conclusion. There are certainly a myriad of reasons why this has happened, not the least of which is the inadequacy of funding for audits done by government intermediaries. However, there are other possibilities that have not yet been definitely addressed by anyone, to the best of our knowledge.

We note in passing that at the time of the negotiations for our third-year contract, that HCFA declined to finance our request to review the intermediary program performance in a more specific way in New York.

It is equally important that the committee bear in mind that an important part of what we and other medicaid fraud control units are about is the concept of deterrence. I cannot overstate its value. As long as we and other units exist and providers remain aware that someone is looking at their actions, and even using such techniques as undercover activities, the greater the possibility that fraud and abuse affecting the programs will be substantially reduced. Obviously, it is impossible to quantify the deterrent savings associated with the medicaid fraud control units, but it is safe to say that the amount of deterrence is far in excess of the program expenses.

That concludes our prepared remarks, but we would be remiss if we did not again thank this committee for its past support and, more importantly, for the farsighted goals it has worked very hard to bring about.

In this age of New Federalism, we would like this committee to be mindful of the fact that the medicaid fraud control units are a very clear example of national efforts to tackle local problems on a statewide level. It is important that Congress, in returning programs to the States, not forget to provide for the effective policing of these programs.

Thank you.

Senator HEINZ. Mr. Friedman, thank you very much.

I think I should note for the record that the State fraud control unit you have is something of a model in the United States, as I understand it. You are a team of investigators, auditors, and lawyers, and in that respect, you have a set of uniquely qualified members operating as a team. And is it not the case that you are probably a stronger unit than almost any other in the United States in that regard?

Mr. FRIEDMAN. I think that would be conceded by everybody in the area, Senator; yes.

Senator HEINZ. Now, in terms of what you have been able to achieve, how many indictments and convictions has your office brought about for frauds related to the operation of hospitals?

Mr. FRIEDMAN. I do not have the statistics with me, but I am sure that we have had well over 100 indictments and possibly close to 80 convictions for hospitals, specifically hospital-related fraud. Of course, we investigate the entire spectrum of medicaid fraud.

Senator HEINZ. I am told that in 1980, there were a total of 144 State fraud unit cases pending against personnel or owners, and all 15 convictions were in New York.

Mr. FRIEDMAN. I have seen those statistics. I apologize to the committee for not having these statistics.

Senator HEINZ. Through 1980, no other State fraud unit has proven successful in prosecuting fraud, as the statistics I gave you just indicated, related to hospital operation. What specific factors account for your office's success?

Mr. FRIEDMAN. First of all, we did get into the area probably before all the other States. Just parenthetically, to note something that you stated before concerning the $1, $26, $75 return, I would just like to add a dimension to that, and that is that our experience is that as you become more sophisticated in the area, the graphics of your findings go up very dramatically. That has been our experience in New York. We started before most other States. We had a major scandal in the nursing home industry. Our body of knowledge is greater than anybody else's, and we are just more sophisticated and, I think, a little further along than most of the other medicaid fraud control units.

Senator **Heinz**. Now, are your recoveries per dollar spent increasing each year?

Mr. **Friedman**. Certainly.

Senator **Heinz**. Now, in your testimony you said that the State fraud control unit could be a very good deterrent—you have one of the best. Yet, what you are finding is that each year, you are making a better return on the investment. That suggests that either you are learning a lot faster than the people who are perpetrating these frauds, or that the frauds are going so fast that it is getting easier for you to find them, and that you are not being able, really, to deter people.

Which is the case?

Mr. **Friedman**. Well, most certainly, I believe it is the former, Senator.

Senator **Heinz**. You are getting better.

Mr. **Friedman**. I think that what I said before does not bear repetition. But I can talk about the hospital contract very specifically. The first year, we spent a lot of time looking at invoices and looking for kickbacks and things like that. By the third year, we were doing very sophisticated audit investigations.

Senator **Heinz**. Do you think people worry in New York State about the fact that you are there and that you do operate as a deterrent?

Mr. **Friedman**. We have a great deal of information that that is the case. We have tapes and things like that, that we have heard repeatedly. People that we have talked to—obviously, we are out talking to people all the time—indicate that that is clearly the case.

Senator **Cohen**. Have you used any sheiks in your operation?

Senator **Heinz**. Well, not yet, I do not think.

My last question is, you have described in some detail the financial manipulation of these programs. I have asked the same question of other witnesses. Do you see any way where the present reasonable cost system of reimbursement for medicare/medicaid can be patched up and retained, or do you think we will have to find a better way of doing this?

Mr. **Friedman**. First, let me say that in New York, as in many other States, there have been a series of experimental programs that are being tried. I do not think that one can conclusively talk about the results of those other programs yet.

I think that Government has to go one of two ways. Either they have to make the effort and spend the money to support the intermediary program, or some other program. It need not be in the hands of the intermediaries that are now conducting the program for the Government—or they have to restructure the type of reimbursement—one or the other. Otherwise, you are really just doing patchwork.

Senator **Heinz**. Thank you, Mr. Friedman.

Senator Cohen.

Senator **Cohen**. Mr. Friedman, I was not clear about your statement, on page 8, as to the understatement of patient days for statistical purposes. What do you mean by that?

Mr. **Friedman**. Well, a per diem rate is calculated by dividing—basically, essentially—by dividing total costs by patient days. So you increase your per diem rate either by increasing the numerator, if I might, or decreasing the denominator in the equation.

If one were to understate patient days, hence the denominator would be less, the division would produce a larger per diem rate.

Senator COHEN. Those would be, I assume, personal expenses charged to the hospital, and included in cost reports; could you give us an example of what that entails?

Mr. FRIEDMAN. Yes; we have found many high-level operators of hospitals who take the staff, take the supplies, and use them for their own personal reasons—to build wings on homes, we have found——

Senator COHEN. Could you detail some of that? That is, I think, a significant finding, but it does not have as much impact as when you tell us that they build personal wings on their homes and charge it to the hospital. Could you give us some more examples?

Mr. FRIEDMAN. Of that particular type of finding?

Senator COHEN. Yes.

Mr. FRIEDMAN. We find chauffeurs, maids, vacations, certainly any kind of personal expense that a proprietor or a high level person may have, is very easy to be run through the program.

Senator COHEN. How do they bury that in a report, for example? How would you bury the cost of an added wing to your house in a report so that it would not be detected? What would you do?

Mr. FRIEDMAN. Well, the only invoices that would show would be invoices from the suppliers. In our particular case, they are employees and suppliers. The invoices from the suppliers read as though the materials were delivered to the facility.

Senator COHEN. Well, let me give you an example. If you are going to put on a frame structure on a house, you would have lumber—would that be consistent with what we mostly conceive of a hospital being built mostly of brick and mortar?

Mr. FRIEDMAN. We, as a matter of fact, had a situation with a great deal of lumber where the hospital was brick and mortar, but I assume that the interior of the hospital must contain some degree of woodwork. But that was our experience, actually.

Senator COHEN. Now, what about chauffeurs, maids, and vacations; how is that reflected? What do they do in terms of the accounting number? What do they put that under?

Mr. FRIEDMAN. Well, the checks go through the fiscal officer of the hospital. What you find is that the owner, or the person who is responsible, is the person who is in control of the internal structure that is there to detect that type of activity. Obviously, an outside auditor is not going to be able, from looking at the records, to determine that this employee was not, in fact, at the facility. They will not even attempt to spot something like that.

Senator COHEN. How did you find it?

Mr. FRIEDMAN. We ended up finding it by talking to people at the facility. We were in a facility, conducting a routine audit, pursuant to the contract. We started talking to people. We got to maintenance, and they referred us back to others——

Senator COHEN. And how did you identify it, going back—I do not understand how you got to the books.

Mr. FRIEDMAN. Very simple. We did a payroll test. By surprise, we showed up, we demanded to be present when payroll checks were dispensed. We found a number of checks left over at the end of a 24-hour shift. I believe that the person who was taking us around was totally unaware of the fictitiousness of the employees. We had some names to check. We went to the departments to which these people were charged, and we could not find them, and ultimately obtained the information where they could be found, that is, the people's residences.

Senator COHEN. On one other point, No. 14, physician billing for services already included in the rate. I guess what struck my mind while you were testifying, is the situation where hospitals try to attract very prominent physicians, which is a normal practice, as I understand it, and a hospital carries on its payroll, nurses and assistants, anesthetists, anesthesiologists, and so forth, to be at the beck and call of a particular surgeon. Are you saying it is solely for the benefit of that particular surgeon that they are set up in that fashion, or do they have the use of those hospital employees to carry on their activities?

Mr. FRIEDMAN. Well, both. The problem really exists more at the lower end of the spectrum, in that there is increased nursing needs as a result of the doctor's private practice, there is increased billing clerk needs.

Senator COHEN. I do not know what you mean by that. What do you mean, as the result of private practice?

Mr. FRIEDMAN. Well, as a result of the fact that the doctor is generating much more business for the facility than would exist without him being under this arrangement with the facility. As a result of that, if his private patients are present in the facility, he is treating them——

Senator COHEN. In other words, he has got a private practice going that is starting to flourish, he has them transferred to the hospital, and the hospital picks up the costs.

Mr. FRIEDMAN. That is correct.

Senator COHEN. All right. Now, what about physician billing for services already included. Do you mean to say that on the one hand, the hospital submits the cost reimbursement voucher which includes the physician's service, as well, and the physician submits a separate one?

Mr. FRIEDMAN. That is correct.

Senator COHEN. Is that widespread?

Mr. FRIEDMAN. It is very widespread. It is not as widespread in medicaid as it is in medicare under the part A and part B billings. The medicaid system is a little different.

Senator COHEN. That is all I have.

Thank you, Mr. Chairman.

Senator HEINZ. Senator Cohen, thank you very much.

Gentlemen, you have been extremely helpful. We appreciate your testimony, Mr. Mitchell and Mr. Friedman.

Thank you.

Our next witness is Merrit Jacoby, director of government affairs with Blue Cross and Blue Shield.

STATEMENT OF MERRIT JACOBY, DIRECTOR OF GOVERNMENT AFFAIRS, BLUE CROSS AND BLUE SHIELD ASSOCIATIONS, WASHINGTON, D.C., ACCOMPANIED BY DAN GREGORIO, DIRECTOR OF MEDICARE PROVIDER AUDIT AND REIMBURSEMENT, CHICAGO, ILL.

Mr. JACOBY. Mr. Chairman, I am Merrit Jacoby. With me is Dan Gregorio, who is director of medicare provider audit and reimbursement for the Blue Cross plan located in Chicago. He is here to help us address technical points in connection with the medicare audit process, should that be necessary.

First of all, we were asked to prepare and present to you a general statement of the current situation with respect to the funding of intermediary and carriers in medicare administration. My statement is directed to that end.

There has been a considerable amount of discussion about the adequacy of the funding of medicare contractors since the latter part of fiscal year 1981, and in fact, some references were made to it by others who have testified here this morning.

These discussions have generated out of a series of decisions which have largely emanated from the executive branch, to reduce funding for carriers and intermediaries. These decisions have reduced 1982 and 1983 funding levels below those considered necessary for sound administration of the medicare program. We believe the Health Care Financing Administration shares this view.

I can say, I believe, on behalf of the contractors, that they are generally supportive of the goals of the administration to constrain the rising costs of the medicare program and health care costs.

The contractors, the intermediaries and carriers, however, are concerned about the lack of an apparent rationale or plan under which these reductions in administrative expenses are being carried out. The contractors are also concerned about the potential for administrative cuts to increase program and benefit payments, which is a matter, again, that has been addressed by previous speakers here this morning.

In the brief time that I have, I will describe the status of our funding situation and our major concerns.

Carriers and intermediaries are funded directly by the Health Care Financing Administration through annually negotiated budgets. Such budgets are called for on an annual basis under the terms of the contracts between HCFA and the intermediaries and carriers. The contract, calls for payments of the actual, reasonable, and audited costs of the contractors incurred in carrying out the administrative directives of HCFA. The contractors are assured by the provisions of the agreement that their participation will be on the basis of neither profit nor loss.

Contractors estimate their reasonable cost before the start of each year, and they submit these estimates in a greatly detailed form as a proposed budget to HCFA. There is a negotiation and finally an approved budget.

These budgets are built from a large body of very detailed general instructions, which are issued to us by HCFA and associated requirements, in terms of what are allowable costs and what are considered generally to be reasonable costs. These instructions cover all aspects of the services that the contractors are expected to perform. They are sufficiently detailed so as to be readily translated into necessary staffing and other cost increments. In short, the budgets cover processes and procedures decreed by HCFA and not at the discretion of individual contractors. These cost increments of each budget are required to be calculated using generally accepted cost accounting principles and to meet prescribed Federal costing requirements.

Thus, the Government sets the rules and limits for what can be recognized as a reimbursable cost of medicare administration.

The budgets are submitted in great detail and include a great deal of information to support and justify the estimated costs. During the operating year, the contractors are required to provide quarterly reports of their actual experience in some detail. Contractors are also subject to and undergo reviews by the Government at almost any time for the purposes of examining these costs and for other purposes—for example, reviewing their performance in audit, medical review, and other functions they perform for the Government. At the end of each fiscal year, the contractors submit a final detailing of their incurred costs. This is audited for reasonableness and allowability before a final settlement is made.

To summarize, contractor costs are closely circumscribed. They are monitored constantly, and they are audited, to assure that they are indeed reasonable, appropriately determined, and properly calculated. Therefore, the issue of cutting expenditures does not center on how to define cost or the Government's obligation to reimburse costs once they have been approved and have been incurred by the contractor. The issue centers instead on whether various contractors activities should be curtailed or deferred, and if given activities are curtailed, what effect the changes will have on the program's purpose and effectiveness. This is relevant to some of the comments that were made this morning in terms of the intermediary's effectiveness and what it does in carrying out provider audits.

Under the agreements between the contractors and the Health Care Financing Administration, contractors carry out instructions only to the extent that we have been funded—that is to say, as long as funds are sufficient to maintain the staffing and the processes incident to those instructions. When the funding allowed is less than is required to carry out those instructions in full, the instructions and their expectations of impact on program expenditures have to be changed.

Under the terms of their agreements with the Secretary, contractors are quite properly not obligated to maintain the same levels of administrative support to the program when the available funding is not enough to carry out those levels of support.

At this time, we believe there can be no question but that the contractors are now providing less service to medicare beneficiaries. They are doing less medical review to identify and control unnecessary and noncovered health care services. And, they are doing fewer and less extensive audits of health care providers, hospitals, skilled nursing facilities, and home health agencies. In that connection, the point was made earlier here that intermediaries do a form of review which does not include field audit. Desk review it is called. The provider submits a cost report, intermediary staff review it without going out to the provider, comparing it with earlier costs during earlier fiscal year, and with other similar categories of cost of other providers. The other form of audit, field audit, is certainly more effective. At this point, I think it is fair to say that we are doing field audits in less than 50 percent of the providers, and that the major audit activity is composed of desk review. And just recently, in connection with the administration's conclusion that the budget should be reduced, we were directed by HCFA to reduce the amount of hours spent on desk reviews from 40 to 15, which is almost a 40-percent cut. That is relevant to the types of situations that this committee is addressing.

In our judgment, this range of constraints and cutbacks is having an adverse impact on both medicare services and benefit levels. This will, if not already has, impacted the integrity of both the substance of the program as well as its administration.

Through all of this, as we have said, it is not clear to the medicare contractor community what rationale underlies all of the administrative funding limitations that have been imposed to date. It is also not clear to us how far into the future these limitations will extend. We hope that it is understood that with each reduction in contractor funding, there will have been reductions in the extent, speed, and quality of the services we have been able to furnish to beneficiaries and to providers. We should note at this point our opinion that, as administrative services are further reduced in the future, a point in time will be reached where beneficiaries will react negatively and vocally.

We also hope it is understood that there have been significant reductions in the extent and quality of contractor reviews of claims of health care services for excessive care as well as for noncovered care. As a result, it is our conclusion that medicare is now paying for more health care than it should because contractors no longer have the funds or the staff to review as many claims as they should—as they were able to as recently as 9 months ago.

You must know that we are auditing fewer hospitals and other health care providers, and this is increasing the payouts from the medicare trust funds. In this connection, it is relevant to note that the administrative costs of medicare are less than 2 percent of the total costs of the program, and that a dollar invested in administration pays for itself several times over in services to beneficiaries and proper control of the much larger benefit dollar payouts.

For example, as has been noted here, every dollar that is invested in the intermediary's provider audit activity today returns $26 in reduced cost. The dollars saved totaled $1.3 billion.

I would like to supplement the written comments at this point by stating that intermediaries are not obliged—they do not have a function, as intermediaries—to audit providers for fraud or abuse. Their function is to audit the providers to assure that they are paid their reasonable costs according to Government stipulation. An audit for fraud and abuse is a different kind of audit, cannot be done in a desk review, and it costs more money.

Senator COHEN. What is the difference between a reasonable cost and an excessive cost? Doesn't that get into abuse?

Mr. JACOBY. The difference is what you do with the records. If you assume that there is the potential for fraud, it is a much more extensive, more detailed, longer lasting review. I appreciate the point you are making——

Senator COHEN. I am saying as intermediaries, they have got the responsibility for looking to find out whether that is a reasonable cost. If they see, for example, that a reasonable cost would be $30, and they find $75——

Mr. JACOBY. That would be a different point.

Senator COHEN [continuing]. That is excessive. That is abuse.

Mr. JACOBY. Fraud is hidden, as a general proposition, is the point I would be making here.

Senator COHEN. Well, the word is "fraud and abuse"——

Mr. JACOBY. "Fraud and abuse."

Senator COHEN [continuing]. Or "fraud or abuse." But it seems to me that intermediaries cannot just shirk their responsibility by saying, "We are checking to see if it is reasonable." What is reasonable may very well determine what is abusive.

Mr. JACOBY. That is correct. We find, as I indicated, $27 in cost adjustments for every audit dollar we now get, and that, in conducting audits of less than 50 percent of the providers, with the majority of the work being done through desk reviews. A much greater return, obviously, could be obtained if we were permitted to do more field audits. I think we stopped doing 100 percent field audits around 1974, at a time when, again, there were budget pressures and a concept called periodic and limited scope audits was introduced.

Among cuts that have been imposed to date on the contractors' administrative capabilities, some of the abatements and deferrals have been agreed to by the contractors as workable and consistent with the circumstances. That is, having minimal negative effect on the program. But there are other instances, particularly in the case of the latest cuts, where the contracts are fairly certain that anticipated reductions in activity cannot be made in ways that will meet the savings goals set by HCFA, or if they are, that the consequences will exceed those intended by either the contractors or the Government in terms of service and program control.

In short, we now find ourselves in a gray area of uncertainty about the effect of the latest round of cuts. It might be argued that the contractors should be able to increase their efficiency and their productivity to help the medicare program and the administration in reaching its goals with respect to the economy. Please be assured that we have been and continue to work to increase both the efficiency and productivity. We are proud of the fact that for almost evevy year of the last 10, we have established a record of doing both. From 1973 to 1979, contractors have reduced their administrative costs by 16 percent without any adjustment for inflation. When adjusted for inflation, the costs have been reduced by 49 percent in that period. In the same period, contractor productivity has been increased by 80 percent, and we will continue those efforts. However, the funding constraints recently imposed and anticipated have gone, in our judgment, beyond the ability to absorb them through efficiency or productivity increases.

The weakening effects of the relevant funding constraints have been aggravated by recent legislative, regulatory, and priority changes in medicare administration. Contractors are being asked to do new administrative assignments, to intensify some efforts, and to adopt to a variety of structural changes in the programs. Each of these changes often generate cost. Because additional funding for such changes is not being provided, other parts of medicare administration which have been established and funded are being reduced to free funds for the new assignments. Therefore, there is currently a two-state impact on what we are able to do. Established operational levels are being reduced to meet the reduced budget amounts and are being further reduced to free funds to implement changes and newly identified priorities. This latter phenomenon might be characterized as robbing Peter to pay Paul. In any case, it has the effect of speeding up the weakening of medicare administration.

The timing of changes in funding for medicare contractors has also had significant effects on their ability to respond and adapt in the most effective manner. When funding reductions are announced to the contractors after the beginning of a fiscal year, the effect of those reductions is increased. Funding limits are stated in terms of cost limits for the fiscal year, an annual period. If a reduction in the fiscal year limit is announced to the contractors after 6 months of that year has passed, the amount of the reduction is doubled because the contractors have only one-half of the fiscal year within which to meet that reduction.

We are facing exactly that situation now, this fiscal year. We do not currently have approved budgets. We may be asked to reduce our total budget for the fiscal year by as much as $25.7 million below the figure that we were authorized and planned for, and staffed for, at the start of the fiscal year. Because 6 months of the fiscal year will have elapsed by the end of this month, that is, before we can expect clear instruction, we may well be obliged to find $51.4 million in reduced level of operations between the end of this month and September 30 of this year, the end of the fiscal year. To do that, it will be necessary to reduce staffing and services to a level below what is expected to be the level of funding for the next fiscal year. That makes it necessary to terminate staff and services which will be needed at the start of the next fiscal year.

Obviously, organizationally, it is not possible to engage in that type of stop-and-go activity without a net loss in efficiency. Aside from the problem that this presents to the contractor community, the stop-and-go effect also impacts services to providers and to beneficiaries. All of us involved in medicare administration are thus exposed to a question of irresponsible management.

The contractors and HCFA are currently studying the cutbacks that have occurred to date to try to demonstrate the true effects of these limitations. The objective is to produce hard data to help assess the effects of the recent series of funding constraints. We recognize that it is not our responsibility to decide whether and when such negative effects become unacceptable programmatically. That is a responsibility of the Federal Government. But we do feel an obligation to provide you with information about what is happening, and you can be sure of our cooperation to this end.

At the same time, we must recognize our responsibility to decide when and if the negative effects of these changes become unacceptable to our own self-image and to the rest of our subscribers.

Thank you, Mr. Chairman.

Senator HEINZ. Thank you very much, Mr. Jacoby.

On page 3 and 4 of your statement you indicated that,

> The contractors carry out medicare instructions only to the extent that they have been funded, as long as funds are sufficient to maintain the staffing and processes incident to those instructions.

Mr. JACOBY. Yes, sir.

Senator HEINZ. I gather the Office of Management and Budget seeks to reduce contractor funding by a relatively substantial amount this year. It is not clear that HCFA supports that, but OMB certainly has been pressing for it.

I am told that yesterday, the regional offices told the contractors they could draw funds only at the rate which would produce the fiscal 1982 spending level of $684 million. That's a $7 million cut. As I understand, about 30 percent of the budget there goes for auditing. That means there will be what would appear to be a very modest cut of $3.5 million or so, in a $145 million budget. Could you tell us what that cut will mean in terms of recoveries, savings to the medicare program? What will $3.5 million in reduced contracts with you for this kind of activity mean in terms of recovery?

Mr. JACOBY. I cannot be precise in giving you a figure, Mr. Chairman.

Senator HEINZ. Well, roughly.

Mr. JACOBY. And I do not know that I should even attempt a rough figure. However, a rule of thumb, as I indicated earlier, is that for each dollar invested in the provider audit activity that intermediaries carry out now, they are recovering $27. That, by some multiplication, should give us a rough figure.

Senator HEINZ. So this $3.5 million savings on the book could end up with something between $75 and $100 million worth of additional costs of going right into the medicare program and being reimbursed by the system.

Mr. JACOBY. Yes, sir; that bears on the point made in the testimony to the effect that we do not understand the rationale for the cuts in that, when investment is made in provider audit, it returns more dollars, many times the dollar that is invested, and generally the same thing is true with respect to investments in medical review and claim review. They return savings out of the trust fund in multiples of each dollar invested.

Senator HEINZ. You recovered, as you said, $26 for every $1; is that right?

Mr. JACOBY. Yes, sir.

Senator HEINZ. I want to ask you the bottom line question here, which is, do you believe that the reasonable cost reimbursement system can be salvaged, and if so, how; if not, do you have an alternative in mind?

Mr. JACOBY. I tend to believe that it can be. I am struck by the fact that the Blue Cross system has been paying providers in many parts of the country on a reasonable cost basis for well over 40 years. During that period of time, the cost of medicare was something like 6 percent of the gross national product or less. I do not understand the conclusion reached by others that a reasonable cost system cannot be operated effectively.

I tend to also feel that—and I believe you yourself made the statement here this morning, if I recall it correctly—that we all accept the fact that the majority of the health care providers in this country—that includes physicians as well as institutional providers—are honest people, dedicated to their work. It is unquestionably true that there is a group with, perhaps, a sharper entrepreneurial spirit than they should have. These people have to be watched. The work that is done by the Inspector General and others addresses that problem. I think sometimes we get some of these situations out of perspective, in terms of what is going on among the largest number of health care providers.

Senator HEINZ. I hope that is not an excessively optimistic statement on your part.

Mr. JACOBY. I hope not.

Senator HEINZ. Let me tell you why I think it may be an exceptionally optimistic statement that you can salvage the present system. As I understand it, when you come across something that is improperly billed, a cost that is improperly assigned, you disallow it.

Mr. JACOBY. Yes, sir.

Senator HEINZ. But how do you recover it? As I understand, the way you recover it is you say you will disallow some portion of a future, yet to be made, reimbursement, because you are catching these things after the bill has already been paid. That is called an interest-free loan. Do you charge interest?

Mr. JACOBY. No.

Senator HEINZ. If I know I can get interest-free loans with no penalty, as long as I am honest in my overbilling, I have got a better deal than a 16 or 18 percent prime rate.

The second observation is that it would seem to me that if I know that I am going to have something disallowed out there in the next set of bills I am going to send through, I am going to work very, very hard to maximize all additional costs I can put into that reimbursement to make up for that loss I am going to get on the payment. Is that a possibility?

Mr. JACOBY. That is a possibility. The implication, I think, in both situations is that somebody does that intentionally for those reasons, and I do not doubt that that exists. Our job is to prevent that. One of the ways we prevent it is we do not pay on a claim by claim basis. We pay an interim rate, which is calculated based on the audited cost to that provider in the previous year, plus any factors he chooses to identify to us which are supportable, that would indicate his costs are legitimately going to be higher in the current year.

Senator, could Mr. Gregorio add something?

Senator HEINZ. Certainly.

Mr. GREGORIO. Just for the record, our experience in Illinois shows that if you were to measure the underpayments to the hospital for a given year against the overpayments for that same year, it may very well be that the Government is getting an interest-free loan—that is on a net basis. In other words, what I am saying is that the rates are set to come as close as possible to the actual expenditures of the hospital during the year.

Senator HEINZ. Well, I understand that sometimes, hospitals get reimbursed slowly and that that represents an interest-free loan to somebody. But I am talking about the disallowances.

Mr. GREGORIO. So am I, Senator. We try to make a professional judgment, which is updated at least quarterly for every hospital, and try to pay that hospital accurately, based upon previous audits, what we know about the hospital's operations currently, and financial data that is supplied to us on Government forms.

Senator HEINZ. And you do not think that they find a way to make up those costs, somehow?

Mr. GREGORIO. Well, the truth can be easily identified and submitted for the record.[1]

Senator HEINZ. All right, let us do that. Just one other question. As I understand it, if I were the manager of a hospital, and you told me I had overbilled, I could hire an attorney to contest that. And, whether I were successful or not—it might drag on for a while—and assuming that I was unsuccessful in contesting that, and I had to, in effect, pay out, who pays for those attorney fees under the present system?

Mr. GREGORIO. Medicare will pick up its share of those attorney fees, as long as they are not out of line compared to other hospitals doing the same type of administrative procedures.

Senator HEINZ. So we, the Federal Government, are paying attorneys for the hospitals to contest things that we are trying to catch; is that right?

Mr. GREGORIO. That is correct.

Senator HEINZ. A healthy incentive to contest, at any rate, as well as some other things.

I thank you all for your testimony. It has been very helpful.

Thank you, Mr. Jacoby.

Our next witnesses are John Hoff and Ted Ackroyd. Mr. Hoff represents the National Council of Community Hospitals, and Mr. Ackroyd is with the Hospital Association of Pennsylvania, by some coincidence.

Gentlemen, because we went longer than we had planned earlier, particularly with respect to the principals involved with the Community Hospital of the Valleys, who had a number of things they wanted to get on the record which had not originally been anticipated, what I am going to do is put your entire set of statements, both from the National Council of Community Hospitals and the Hospital Association of Pennsylvania, into the record in their entirety.

I would ask that you summarize any key points as briefly as possible. The reason for that is that we are going to be interrupted very soon by a vote, by a buzzer, and we are just going to have to move along. I apologize to you both for this inconvenience.

Please, Mr. Hoff, proceed.

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[1] Not received at time of publication.

STATEMENT OF JOHN S. HOFF, ESQ., REPRESENTING THE NATIONAL COUNCIL OF COMMUNITY HOSPITALS, WASHINGTON, D.C.

Mr. HOFF. Thank you, Mr. Chairman. I will be very brief and will summarize the summary.

First, let me get to your bottom line which you have asked the previous witnesses and really make it my top line. The reasonable cost reimbursement system should be ended. At one and the same time, it provides too much reimbursement and too little reimbursement. It does not give hospitals enough money to operate on a fair and fiscally responsible basis, even if it were fairly applied, because there is no excess of revenues over cost. And it has not been fairly applied by the Government. It has been used by the Government to save money in its fiscal crisis.

There is now general agreement that medicare is getting a substantial discount on the cost of taking care of medicare beneficiaries. That shortfall the hospitals must recover from some other source, and they are now forced to ask the paying patient to pay that. This means that a very few patients have to make up a very large deficit incurred by the Government.

Also, reasonable cost reimbursement is run by a series of complex and arbitrary rules, enforced by an army of accountants and auditors; the paperwork is overwhelming. You have heard testimony all day today about it.

The system hurts the hospital which is acting in good faith, yet, as I think the testimony has also indicated, does not catch the provider interested in cheating the system and cheating the taxpayer.

Reasonable cost reimbursement, most importantly, though, introduces the wrong incentives into the system. There is no economic concern by the patients, the hospital, or the doctor as to the cost of hospital care. There is no economic benefit for the hospital to reduce its costs. On the contrary, a hospital may be financially injured by doing so.

The reasonable cost reimbursement system encourages and enables hospitals to compete in terms of equipment and buildings, and it prevents them from competing in terms of price.

In an effort to control the effects of reasonable cost reimbursement, the Government has strapped a regulatory stranglehold over the system. What is known as the Planning Act is nothing more than a euphemism for tight regulation. Hospitals are subject to the most intrusive regulation of any field in this country. Almost any decision made by a hospital is subject to review and decision by a long series of Government agencies and Government-sponsored agencies who do not have the necessary expertise, but do have their own agenda; most importantly, they are determining how health care is delivered but do not bear the responsibility for the results.

The example of CAT scanners is often given. The fact that must be remembered is that there is no right answer as to how many CAT scanners there should be, or where the CAT scanners should be located.

There is little disagreement that reasonable cost reimbursement must be ended. The real question is how. One idea which has been around, as you mentioned earlier, Mr. Chairman, for a number of years and is currently being bruited about again, is something called prospective reimbursement. Under this, the Government would set a rate ahead of time. I would urge, though, that this system is unworkable and counterproductive. It will only continue the reasonable cost reimbursement system. It does not change the incentives of reasonable cost reimbursement. It is merely an attempt to put several more lids on a boiling pot. It is just ratesetting by the Government. It is, clearly and straightforwardly said, price controls. Price controls do not change incentives; they do not work over the long run.

Beyond that, prospective reimbursement will require extra and incredibly complex layers of regulation. The Government will be required to categorize illnesses and classify hospitals. This cannot be done. The field and medical care are too complex to put into bureaucratic pigeonholes.

The present system, as you have heard this morning, is already too complex to run. Prospective reimbursement would be, if you can believe it, far worse. The best and only hope, Mr. Chairman, is, as you have advocated on a number of occasions, eliminating reasonable cost reimbursement and going to what is now called competition. People can choose, under competition, between competing plans and competing providers. The providers will be deprived of the support and the cushion of reasonable cost reimbursement and will be forced to engage in price competition. This also means, though, that the providers who are not able to be efficient will lose in that competition. At the same time, the providers that are efficient and meet a need recognized by the community will benefit from doing so.

People must be given assistance by the Federal Government, as they are now, to obtain care. This includes particularly the medicare beneficiaries. But that assistance must be structured so that, first, it feeds into a competitive system, and so that second, those beneficiaries have an economic incentive to choose among providers on the basis of price, as well as of quality. But given that incentive and that assistance and given a competitive system where the providers are competing, the patients and the providers who take care of them, with an economic stake in their decision, can decide how health care should be delivered and how much they wish to spend for it. This is, in the final analysis, far better than having the Government make those decisions in a complex and politically difficult regulatory system.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Hoff follows:]

PREPARED STATEMENT OF JOHN S. HOFF

My name is John Hoff. I am counsel to the National Council of Community Hospitals and am appearing on its behalf. NCCH is an organization of approximately 100 community hospitals throughout the country which are working to reform the health care financing and delivery system.

NCCH members believe that the medicare reimbursement system of reasonable cost/reasonable charge reimbursement is wrong as a matter of public policy. Medicare reimburses providers for care given to the Government's beneficiaries by paying reasonable costs to hospitals and customary charges to physicians. This reasonable cost reimbursement system provides, at one and the same time, too much reimbursement and too little.

Hospitals and doctors are encouraged to purchase equipment and to provide services. The more they buy and the more they provide the greater their revenue. They compete in terms of equipment and buildings. They do not benefit from reducing costs, and do not compete in terms of price.

On the other hand, Government has failed to pay hospitals their reasonable costs. By a series of actions, it has whittled away at reasonable cost reimbursement so that it pays hospitals (particularly nonprofit hospitals) substantially less than the actual cost of caring for Government-assisted beneficiaries and less than those beneficiaries' fair share of the hospitals' costs. The reasonable cost concept makes no allowance for the fact that even not-for-profit hospitals need a "profit" to provide them with working capital and discretionary funds.

Reasonable cost reimbursement enables the Government to make arbitrary, unilateral, and retrospective decisions on the amount a hospital can receive for its services. The Government has on numerous occasions restricted what it considers reimbursable not because the service was unreasonable or unnecessary or because the cost of the service was unreasonable as a financial matter, but only because the Government sought ways to reduce Federal expenditures for health care.

The Government has transformed a system that was designed and intended to prevent hospitals from overcharging the Government into a mechanism for underreimbursing them.

An effective health care system cannot be operated under the gun of self-serving reimbursement decisions by the Government. A purchaser of hospital services (as the Government is on behalf of medicare and medicaid patients) cannot be permitted to "purchase" hospital services and unilaterally determine, after it has received the services, what it designs to pay for them. It is "Alice in Wonderland," and it does not work.

"Reasonable cost" carries with it an army of federally employed and federally activated accountants whose sole mandate is to save the Federal dollar without consideration of the effect on quality care or provision of service.

Because the Federal Government refuses to pay hospitals the actual cost of caring for medicare patients, hospitals must make up the difference from their charge-paying patients. But the number of charge-paying patients is limited, and it is becoming more difficult for hospitals to offset the increasing shortfalls in reasonable cost reimbursement from the charge-paying patients. Hospitals are being forced to use depreciation funds and endowment funds which have been set aside for replacement of obsolete equipment to continue providing service.

Hospitals today are being seriously underfunded. The reasonable cost methodology has trapped hospitals on a treadmill of minutiae that the Government is turning ever more rapidly. Hospitals can never catch up. Under "reasonable cost," they can never obtain the financial stability necessary to provide effective and sensitive hospital care over the long term.

The Government itself is dissatisfied with the reasonable cost system. Its main complaint is that the system encourages unbridled spending by hospitals. In an effort to offset what it sees as the blank check nature of reasonable cost reimbursement, Government has imposed a complex and instrusive regulatory hammerlock over practically every aspect of health care delivery. The regulatory system is run through the reimbursement system and through the planning process. Planning is a euphemism for regulation. To an increasing extent decisions on how care is provided are being made on the basis of political consideration and bureaucratic decrees.

The regulatory system which has developed can only ossify and rigidify the health care delivery system. Continuation of the present trends will bring ever-increasing Government regulation and produce the worst of both worlds—a health care delivery system controlled by Government functionaries who do not suffer the consequences of their actions but who can blame the bad results on hospital "inefficiency." Local and private decisionmaking would be eliminated. Hospital management would be devoted to dealing with the complexities of regulation rather than to innovative management. Health care would be allocated and rationed on the basis of political pressures. Quality of care certainly would be diminished.

Reasonable cost reimbursement and its attendant regulatory structure should be eliminated. It should be replaced by a system that introduces economic incentives into health care, and replaces bureaucratic regulation with the discipline of economic competition. Providers must be required to engage in competition based upon price as well as quality. Medicare beneficiaries should be given the opportunity to make their own decisions, by choosing among competing plans and providers, on how they want their health care delivered, and they should be given the economic incentives to make that choice upon price as well as quality considerations.

The most comprehensive legislative proposal to create a competitive system is the National Health Care Reform Act (H.R. 850). This would make the changes necessary to implement competition across the board and permit the entire working population and medicare beneficiaries to participate. It also would, over time, federalize medicaid. A related bill, the Voluntary Medicare Option Act (H.R. 4666), introduced by Congressmen Gradison and Gephardt, is focused exclusively on reforming medicare. It would give medicare beneficiaries vouchers, if they choose to participate, to use in payment of premiums of qualified plans. To be qualified, a plan would be required to provide at least the same benefits as medicare does now. Beneficiaries could choose among the plans, and make their own choice. They would have an economic stake in this decision, since they would have to compare the premium with the amount of the voucher and could receive a cash rebate if the premium of the plan selected was less than the voucher.

These bills would make fundamental changes in the medicare reimbursement system. They would introduce cost sensitivity into the system. They would change the incentives. This is necessary. Tinkering with the system will not make it better and will only add new complexities and new regulatory anomalies.

The proposal currently in vogue to reform medicare by introducing "prospective reimbursement" is a waste of time and effort and would, if implemented, be counterproductive.

Prospective reimbursement is a euphemism for ratesetting by the Government; the Government would set the prospective reimbursement rate, no matter how that fact were camouflaged by ostensibly sophisticated mechanisms. Prospective reimbursement does not eliminate reasonable cost reimbursement; it is simply another of a series of valves and lids put on the system. It does not change the incentives of physicians or of patients. It gives patients no need to consider the cost of care.

Prospective reimbursement schemes necessarily entail complex regulatory measures. They are based on the assumption—totally erroneous in practice—that hospitals can be classified and judged on the basis of comparative performance within a classification. Hospitals, like other active and changing organizations, are far too complex to be pigeonholed in this way. In order to create the artificial uniformity necessary for prospective reimbursement, these proposals include an inordinate amount of complex and arbitary regulatory provisions, which in the final analysis yield arbitrary and fortuitous reimbursement results.

To alleviate these problems, prospective reimbursement proposals typically give the Government power to grant exceptions. In the final analysis, therefore, prospective reimbursement becomes a system whereby the Government determines what hospitals are paid, even though Government is not the one receiving the care. The rate is set by a Government-determined methodology, the Government calculates the rate, and the Government decides whether to confer exceptions from the rates determined by that calculation.

We cannot fashion an acceptable system for compensating hospitals for services performed on behalf of Government-assisted beneficiaries if we continue under a reasonable cost system. That system will not work. There is no sense in tinkering with and forever patching new leaks in a system, the philosophical premises of which are no longer valid.

We must develop a new system which eliminates the perverse incentives of the present system, introduces cost-conscious incentives, and enhances management motivation and discretion. Health care management should be freed to concentrate on the real problems they confront rather than being required constantly to react to Government-created strictures on how hospital care should be provided and paid. Hospitals, patients, and providers should have economic incentives to provide quality care in the most efficient, cost-conscious way possible. Decisions on how much the country wishes to allocate to health care should be decided by the people rather than the Government.

These goals can be achieved only be replacing reasonable cost reimbursement with economic competition, and Government regulation with decisionmaking by those most directly concerned—patients and those who care for them.

Senator HEINZ. Mr. Ackroyd, as I understand your testimony, if I may summarize from my knowledge of it, first, you would view the problems associated with medicare reimbursement from the hospital's point of view; indicate that in calculating the reimbursement costs, the medicare program disallows some expenses incurred by hospitals, or does not cover a proportionate share of certain expenses, and meanwhile, despite the pared down reimbursement rates, hospitals must meet an increasing demand for health care services. Second, you comment on a few of the administration's budget proposals, such as the 2 percent across-the-board hospital medical cost reductions. And finally, you offer an extensive model of fundamental changes in financing, needed to keep down health care costs. And it is my reading of that model—correct me if I am wrong—that it rests on the assumption that the lack of marketplace controls on the utilization and production of health care services has caused inflationary behavior on the part of both consumers and producers of health services.

Mr. **Ackroyd**. That is correct.

Senator **Heinz**. How would you like to add to that summary, because you have a very complete and helpful statement. I am getting very nervous about the time, since the lights just went off. That usually means that new ones are about to go on.

What would you like to add to that? Please proceed.

STATEMENT OF TED J. ACKROYD, PH. D., HARRISBURG, PA., VICE PRESIDENT, DIVISION OF HEALTH ECONOMICS AND FINANCE, THE HOSPITAL ASSOCIATION OF PENNSYLVANIA

Mr. **Ackroyd**. Well, the bottom line question which you have asked, we respond to in recommendation No. 1 that, in fact, the cost-based reimbursement system does need to be eliminated and replaced by marketplace incentives. We do have a series of seven recommendations. We have attempted to summarize by contrast, today's environment with what we propose to be tomorrow's environment, where there is the sharing of the risk, a sharing among providers, consumers, and insurers.

What you see there is really an abstraction from a slide show which, within the State of Pennsylvania, the Hospital Association is using to educate boards of hospitals, to educate other health care groups, and consumer groups, so that they can see that we as an association, representing over 230 members, do in fact believe there must be a systemwide series of changes.

As you well know, we are working with the Governor's task force to address health care expenditures in Pennsylvania, and in fact, these recommendations and the entire model have been accepted by the subcommittee of that task force addressing payment systems. That subcommittee is comprised of the secretary of health for Pennsylvania, the president of Pennsylvania Bell, several Blue Cross plans are represented, as is the deputy insurance commissioner.

Senator **Heinz**. Could I ask the staff just to go through those recommendations?

How is situation B different from prospective reimbursement?

Mr. **Ackroyd**. Prospective reimbursement may, in fact, be one option. It is not, however, the option which we are recommending. It may, in fact, apply within that situation B.

Senator **Heinz**. All right. I think we have all seen the charts, because they really comprise a way of getting to situation B; do they not?

Mr. Ackroyd. Yes, they do. I would like for the record to show recommendations 6 and 7 so that we can see the entire set.

Senator Heinz. Let us look at them one at a time.

Mr. Ackroyd. It is this recommendation where I identify the need for sharing the risk, sharing the expenses, between the consumer, the purchaser, and the provider.

Senator Heinz. And how would you suggest that that really takes place? What is the mechanism?

Mr. Ackroyd. I am glad you asked because, in addition to these recommendations, we have followed through with an implementation plan which has also been submitted for the record. Only part of that plan has been submitted. We believe that there are responsibilities which the government should take, in terms of moving toward eliminating the cost-based reimbursement system; there are responsibilities that business and industry should take, in terms of working out innovative programs, as some of them currently are, with insurers and with providers of care, and there are responsibilities that the providers themselves should work out, in terms of creating linkages between hospitals and physicians, home health agencies, long-term care facilities. We believe there are responsibilities that each group should assume, and we have tried to delineate the basic elements of those responsibilities.

Senator Heinz. In the attachment to your statement, there is a very excellent explication, summary, of your analysis of all of these recommendations and how you got to them. Your prepared statement and attachments will be entered into the record at this point.

[The prepared statement of Mr. Ackroyd follows:]

Prepared Statement of Ted J. Ackroyd

Mr. Chairman, I am Dr. Ted J. Ackroyd, vice president of the division of health economics and finance of the Hospital Association of Pennsylvania (HAP). The HAP, which represents over 230 member hospitals and other health care institutions, is pleased to have this opportunity to present its views on the problems associated with the medicare reimbursement system as it is applied to hospitals.

It is important to note at the outset that my testimony today summarizes not only the problems with the medicare reimbursement system, but furthermore, I would like to take this opportunity to comment on the medicare proposals recommended by President Reagan for fiscal year 1983. Moreover, I will offer, for your consideration, a series of recommendations which, if followed, would focus on fundamental reforms and end the tinkering approach to fixing what ails the reimbursement system of payments to hospital.

BACKGROUND: THE PROBLEMS ASSOCIATED WITH THE MEDICARE REIMBURSEMENT SYSTEM AS IT IS APPLIED TO HOSPITALS

Hospitals share the concerns of the administration and Congress over the continued rapid increase in the cost of providing hospital services, and the resultant pressure on the Federal budget. In good faith, hospitals worked with Government in implementing a number of programs (e.g., professional standards review organizations and health planning), which at one time appeared to hold the promise of effective cost restraints. It has become clear, however, that these programs have become ineffective.

In addition to federally mandated cost control programs, about 6 years ago, hospitals worked among themselves and with other groups in the health care industry, and successfully launched a voluntary program—known as the voluntary effort (VE)—to restrain costs. As an interim program, the VE worked, against considerable odds in a highly inflationary economy.

Regardless, despite hospitals' own efforts, despite reimbursement reductions and despite the now oft-repeated threats calling for hospital cost controls by some in

Congress and others in government, hospitals continue to find themselves stalemated by the entangling web of conflicting pressures and expectations.

Payments to hospitals for services are being restricted from virtually all sources, thus the options for shifting shortfalls from one payer to other payers is narrowing each year. In fact, the survival of several hospitals in Pennsylvania and throughout the Nation is in serious jeopardy, because their costs outstrip revenue gains. And to add to this burden, new pressures here in Washington to reduce health care spending could make the survival of even more institutions an impossible task.

As you know, the medicare program does not pay full costs for the aged and disabled patients it insures. Also, the medicaid program, which pays under its own cost-based formula, does not pay the full costs of hospital care. And because Blue Cross is so large in Pennsylvania, and in many other States, it has been able to negotiate discount reimbursement rates with hospitals because it is a high-volume purchaser of hospital services. Because these three major third-party payers don't cover all costs of care, certain costs are shifted to the few hospital patients who are covered by other private insurance plans or who otherwise pay for their care.

In terms of the medicare program, hospitals are reimbursed on the basis of what medicare calculates a hospital's costs to be, and this usually is 12 to 15 percent less than what patients are charged. Also, in calculating reimbursement costs, the medicare program disallows some expenses incurred by hospitals, or does not cover its proportionate share of certain expenses. Moreover, for the past decade, the Federal Government—through regulations—has been whittling away at medicare reimbursement to hospitals. Allow me to cite of many examples of such regulations.

In 1979, a malpractice rule was established by the Secretary of Health and Human Services, to allow the Secretary to avoid payment to providers for costs of malpractice insurance premiums attributable to medicare patients on the basis of the ratio of paid claims of medicare patients to total paid claims of all patients in the cost-reporting period at issue, plus the preceding four cost-reporting periods. In absence of any malpractice paid losses during these years, a hospital is reimbursed a percentage of the costs of its medical malpractice insurance premium equivalent to "the national average."

For example, the percentage apportioned to fiscal year 1980 was 5.1 percent. If a hospital's caseload included 50 percent medicare patients, and it paid no malpractice claims (in other words had an excellent medical malpractice record), then only 5.1 percent of its medical malpractice insurance premium would be reimbursed by medicare. If this premium were $100,000, then medicare would reimburse the hospital for $5,100,[1] and the remainder of these insurance costs would be shifted disproportionately to charge-paying patients.

However, if another hospital with a 10-percent caseload of medicare patients paid one medicare malpractice claim, then medicare would reimburse the hospital for 100 percent of the $100,000 insurance premium, without consideration of the hospital's small caseload of medicare patients. Likewise, if another hospital had a 70-percent caseload of medicare patients, and one nonmedicare malpractice claim paid, the hospital, which had no medicare malpractice claims paid, would receive no reimbursement from the medicare program for the hospital's malpractice insurance premium.

Obviously, this is a perverse reimbursement rule because it provides a fiscal incentive favoring paid malpractice claims for medicare patients. Further, it ignores the hospital's caseload of medicare patients, and therefore does not pay a proportionate share of the hospital's malpractice insurance premium. This absurd rule is only one of many rules that are designed to pare down medicare reimbursement to hospitals.

Meanwhile, despite reduced reimbursement rates, hospitals are expected to meet an increasing demand for health care services. Also, Federal and State law, as well as the expectations of the citizens of this Nation, require hospitals to render care to those who ask for it, regardless of the ability to pay for services rendered. Clearly, shifting the cost of caring for the sick and the aged—with their often limited financial resources—isn't the cure for what ails the cost-based reimbursement system.

Furthermore, in terms of medicare program costs, this Federal health insurance program is headed for hard times in this decade and beyond. The policy dilemma facing us is how to change the reimbursement mechanism in ways that will make it more cost-effective, and at the same time, provide needed, quality health care services to the citizens of our Nation.

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[1] Malpractice insurance costs are proportionately shared among payers. Thus if 50 percent of a hospital's caseload is medicare patients, then the medicare program should reimburse 50 percent of the $100,000 insurance premium, or $50,000. Instead, the program reimburses only $5,100 of its $50,000 share in this instance.

With this background, I would like to briefly comment on a few of the budget proposals offered by the Reagan administration as they relate to the medicare program.

—*Disallow 2 percent of hospital medicare costs.*—The administration proposes to reduce medicare reimbursement to all hospitals by 2 percent. We strongly oppose this proposal because it would actually penalize those hospitals that have been most active in controlling medicare costs. Furthermore, it also would severely penalize those hospitals with a high medicare caseload.

—*Apply the hospital insurance portion of the payroll (FICA) tax to Federal employee wages.*—The administration proposes that the hospital insurance portion of the FICA tax, which finances part A of medicare, be imposed on Federal employee wages beginning in calendar year 1983. We support this proposal and an appropriate public policy decision. While most Federal employees currently qualify for medicare at age 65, they do not contribute commensurately to the hospital insurance fund.

—*Reimburse radiologists and pathologists at 80 percent of charges.*—We reserve judgment on this proposal, but I must point out what would result from enactment of this proposal. The 20-percent coinsurance which would be instituted would be borne by medicare beneficiaries. For hospitals with contractual arrangements with these specialists, the shortfall in reimbursement would require the hospital to bill the patient in order to recover that portion which the hospital owes the specialist by contract.

—*Establish a single reimbursement limit for skilled nursing facilities and home health agencies.*—The administration proposes to establish a single reimbursement limit on reasonable costs for hospital-based and freestanding skilled nursing facilities and a single limit for hospital-based and freestanding home health agencies. We oppose this provision because it does not take into account the cost difference resulting from medicare reimbursement rules on overhead charges and other associated costs. Further, it does not account for the more severely ill patients treated by hospitals and the complicated and intensive services hospitals provide.

Mr. Chairman, some of the administration's fiscal year 1983 medicare proposals—such as the 2-percent across-the-board reduction in medicare reimbursement to hospitals—are discouraging to the hospital industry because this type of tinkering repeats past mistakes and does not address the fundamental questions of restructuring health care financing.

We do, however, support further work on consumer choice/competition proposals and we encourage the administration's study of using prospective payment for medicare hospital services. But only fundamental changes in health care insurance, financing and payment would permit hospitals to break the current pattern of conflicting pressures whereby most payments to hospitals are being reduced, yet hospitals must meet escalating demands which they cannot control.

We understand the budgetary pressures on Congress and the administration and stand ready to participate in major reforms which will move toward solution of those budgetary problems and reduction in the growth of health care expenditures. We cannot accept mere tinkering that imposes the wrong incentives on medicare patients and providers.

FUNDAMENTAL FINANCING CHANGES ARE NEEDED SO THAT HEALTH CARE EXPENDITURE INCREASES CAN BE MODERATED

As I stated at the outset of my testimony, I would like to take this opportunity to briefly explain why hospital costs are so high, and furthermore, to recommend a strategy to change hospital financing in the future. If you want more detailed information on the points I will raise here today, I've written two papers on these subjects, and they are attached to this testimony as exhibits A and B.

The first point I want to raise is that I believe it is the lack of marketplace controls on the utilization and production of health care services that has created the basic problem facing the health care industry today. The absence of these marketplace controls has caused behavior patterns on the part of both consumers and producers of health care services which have been excessively inflationary.

To an ever-increasing degree since 1966, hospitals have been reimbursed for their inpatient production expenses "no matter what the cost." Physicians providing services to hospital patients generally are reimbursed their full fees, and in most cases, the full-service and first-dollar coverage of their patients has meant there is virtually no restraint on the number and type of services and tests physicians will order and/or perform for their hospital patients. Similarly, patients generally have behaved in an inflationary manner. Most patients want and expect "nothing but the best" because their health is at stake and their health insurance will pay for most of it.

These behavior patterns are all very rational. There has been virtually no risk: Hospitals know they will be paid for most of their production costs; physicians know they will receive their fees; patients know it won't cost them much, if anything, for their hospital bills. Employers contribute to employee health plans, and the employer's contribution to a health plan is not taxable income to the employee. In addition, the employer may deduct the contribution from its taxable income. Therefore, no single group can be singled out for responsibility for the health cost problem. Insurers, hospitals, physicians, consumers, employers, and current tax policies are all responsible for the high cost of health care. Now, if the problem is really a shared one, then I would ask why shouldn't we all share the burden of the solution?

The trouble with the shortrun solutions being proposed by the administration (e.g., the 2-percent across-the-board reduction in medicare reimbursement to hospitals), is that they are usually one-sided. These types of "solutions" tend to single out hospital, even though others share in the responsibility for rising health care expenditures.

I would like to offer, for your consideration, a series of recommendations which, if followed, would help to address this most serious cost problem. My recommendations involve all parties, not just hospitals, in the solution to the basic problem before us. In order to better understand my recommendations, I would like to begin with a summary description of "today's" world in hospital financing. Then, I will move into a description of what "tomorrow's" world could look like.

After I've compared both worlds, I will move into a series of seven recommendations for change. Here, you will see that insurance changes are a critical component in the future system of financing for health care. Under this future system, insurers would have a pivotal role in changing both utilization and production patterns so that health care expenditure increases would be moderated, and thus marketplace controls would emerge in the future financing of health care.

At this point in my testimony, I would like to turn your attention to several charts that I will use to walk us through today's world in hospital financing, as well as tomorrow's world, and my recommendations for change.

Mr. Chairman, members of the committee, thank you for this opportunity to testify today.

Exhibit A

AN INTRODUCTION TO DETERMINE HOW THE REIMBURSEMENT SYSTEM FOR HOSPITAL SERVICES SHOULD BE STRUCTURED SO AS TO ENCOURAGE EFFICIENCY AND MINIMIZE UNNECESSARY UTILIZATION AND INVESTMENT IN HOSPITAL RESOURCES

Will "tomorrow" be the same as "today" in hospital finance? The answer is a resounding "No!" What does "today" look like in hospital finance, and how and why must "tomorrow" be different? The first three sections of this paper are intended to establish an understanding of some important dimensions of hospital finance "today" and the economics of hospital finance "tomorrow." The last section of this paper provides guidelines for the evolutionary process needed to implement the economics of hospital finance "tomorrow."

Decisions to purchase goods or services by individuals and organizations are generally based in part on the price of the goods or services. If the product is absolutely essential, then price is less important than another determinant of demand—need. Still, if the purchaser must pay for the product and the price is relatively high, there may be a search for available lower priced substitutes. These behavioral characteristics describe a (purchasing) pattern which economists have long studied and which they refer to as the phenomenon of economic rationality *** that is, behavior which responds to economic incentives. Purchasing decisions are generally determined, at least in part, by price; if the price appears relatively too high, a search for lower priced available substitutes may occur *** economic rationality in action!

In matters of hospital finance, this behavioral concept called economic rationality is most important. Hence, parts I through III of this paper seek to create an increased awareness of hospital economics and to develop an interrelationship between hospital economics and hospital finance.

Carrying forward with this concept of economic rationality—responding to economic incentives—consider for a moment two contrasting situations, both of which are possible for hospitals:

Situation A (today): Institution X has a product for which the per unit price is simply the sum of the cost of the factors (inputs) required in its production. This institution is paid what it costs for those factors required to produce the product. This situation describes the prevailing hospital environment.

Situation B (tomorrow): The product which institution Y produces has a price which is related to the costs of production, but it is not simply the sum of the cost of those production factors. In order to sell its product the price has to be competitive. On the other hand, the price must be high enough to cover the costs of factors required to produce it. There is no guarantee that institution Y will be able to cover its costs. This situation is the typical marketplace and is the one toward which the health and hospital sector is moving.

If you were a decisionmaker in both of these situations, even the most basic production questions—"Should I produce?"—"Should I continue to produce?"—would be viewed differently in each situation. Even to ask the question in situation A is almost irrelevant. If fact, the converse—"Why shouldn't I (continue to) produce?"—seems almost more appropriate. In fact, this converse question is really economic rationality in action, that is, you as the producer would be responding to economic incentives. But we are getting ahead of the story.

Let us examine this concept of economic rationality by investigating both of these situations in more detail. Decisionmakers must be aware of the changing environment in which hospitals are operating—an environment where one of the most basic changes is an alteration of economically rational behavior patterns. It will be seen that this alteration must in fact occur if an institution is to survive and, even more important, thrive in an increasingly price-competitive environment.

I. ECONOMIC RATIONALITY

Recall that in situation A (today), you as the producer are paid what it costs to produce the product. The purchaser of the product and the receiver of that product are generally not one and the same. The purchaser is generally the insurer (Government, Blue Cross plans, commercial carriers). The receiver of the product, the patient, does not have to worry about price—so, price is not a determinant of demand. There is no search for lower priced available substitutes.

The purchaser and receiver of the product have indeed become separated; the marketplace has been interfered with and the resultant behavior of the producer has been altered in an economically rational manner. The most basic economic question now becomes: "How can I insure payment for my factors of production?" In fact, still in an economically rational context, the question has been extended to: "How can I maximize reimbursement for my factors of production?" These questions do indeed reflect a response to economic incentives; but they do not in fact suggest behavior patterns characterized by production efficiency and effectiveness.

What are the characteristics of this economic behavior pattern where there are attempts to maximize reimbursement? An elaborate system has evolved which has become known primarily as a cost-based reimbursement system. This is the predominant reimbursement pattern in effect within Pennsylvania. The financial status of Pennsylvania's community hospitals has, in fact, become increasingly dependent upon this elaborate reimbursement structure developed by cost-based, third-party payers. Key features of this structure include:

—*Cost-based reimbursement.*—This is the dominant type of reimbursement for services provided by Pennsylvania's community hospitals. It means that a third-party payer (Blue Cross, medicare, medicaid) reimburses an institution of costs incurred in rendering services.

—*Allowable costs.*—The cost-based payers have established guidelines as to what they will pay for, that is, they have identified allowable costs and established these by policy, regulation, and/or contract with hospital providers.

—*Cost allocation.*—This is the process by which the allowable costs are allocated within an institution's production areas, and it is the basis for determining the level of the cost-based reimbursement.

—*Cost reports.*—These are detailed summaries of costs incurred in the production of hospital output. They serve as the basis for yearend settlements with providers; cost reports are audited to establish final payment due to or from the provider in relation to the particular third-party carrier.

—*Charges (versus costs).*—Cost-based payers do not, of course, pay on the basis of a provider's charges; however, some payers (e.g., self-pay commercials) do pay hospital charges. While these charges or price levels are not market-determined, payment by charge-paying users does represent a means by which institutions can create a bottom line which more closely approximates revenue and expenditure equality. Given the regulatory and contractual restrictions imposed by cost-based payers, it follows that the bigger the charge-paying patient mix of an institution, the better is that institution able to meet its full financial requirements.

These key financial terms in the main serve to characterize the current reimbursement structure. Cost documentation has been and is basically an accounting function; it is absolutely essential under conditions of cost-based reimbursement.

These features really do characterize a system of reimbursement which has evolved entirely in accordance with economic rationality—decisionmakers have responded properly to economic incentives. The "only" problem is that these incentives have been reimbursement incentives, or reimbursement for the input (factors) of production. They have not been output-oriented incentives, that is, these economic incentives have not been directly related to output or product.

Accounting for or documenting hospital costs for purposes of reimbursement is not equivalent to an economic justification for the costs incurred in production of the hospital output. Economic justification is, in fact, a marketplace phenomenon, deriving from the interplay of marketplace demand and supply forces. But, as previously noted, this interplay has not been fully in effect in the hospital sector. On the supply side of this ledger, the hospital as a supplier of services has indeed documented production inputs for reimbursement purposes; but management has not generally subjected the production process to economic analysis. Failure to conduct such analyses actually has been economically rational—to study the economics of the production process would not be an efficient use of human capital when the producer knows that costs will be covered * * * and not by payment for the product, but rather by reimbursement for the inputs "no matter the cost."

Situation B, on the other hand, suggests a more typical marketplace environment. In this situation, there is a relationship between product price and the costs incurred in producing that product. The suggested environment is not, however, typical of the hospital sector currently. The producer is in fact at risk in this market—if the product price is not competitive, potential purchasers will seek available substitutes. Yet, if the price is not high enough, the producer risks an inability to cover production costs. This concept of risk has not been operative in the hospital sector. As has been suggested, economic behavior in a risk-free environment differs significantly from what it would be in an environment where in fact there are risks.

Now, if situation B (tomorrow) becomes applicable to the hospital sector, then economically rational behavior patterns will change significantly. The basic economic question will shift from "How can I insure (maximize) reimbursement for my factors of production?" to "Should I (continue to) produce?" To answer this question, the hospital producer will have to address considerations like:

(a) Appropriate resource combinations—that is, how the factors of production could be combined most efficiently and effectively.

(b) Sizes of the various producing units—hospital bed capacity, intrahospital department sizes, etc., need to be considered in the context of service area need such that production economies of scale (and not diseconomies) can be realized wherever possible.

(c) Areas of product emphasis—that is, what services should be produced given: (1) The services available in the region; (2) the type and distribution of institutional and individual providers; and (3) area population characteristics.

(d) The availability of substitutes and both the willingness of and the economic rationale for providers (be they institutions or individuals) to utilize these.

(e) The appropriateness of vertical and/or horizontal integration—where these refer to control over the factors of production at more than one level (vertical integration) and an integration of various providers of similar type (horizontal integration).

(f) Product price and its relationship to various cost and revenue measures, plus the desired "profit margin."

(g) Product distribution—in a hospital sector context, this refers to the institution's service area.

As a producer "at risk," the hospital producer, acting in an economically rational manner, thus will be conducting economic analyses of the production process and market conditions as a requirement for the hospital to become or to remain competitive. The general purpose for applying these concepts would be to establish the best production process(es) for hospital output(s) such that the charges or price levels decided upon were competitive.

Given the changing reimbursement and delivery system environment in which hospitals are now operating, application of these economic terms will become increasingly necessary. Indeed, we shall see a shift from a primary emphasis on cost documentation (situation A) to economic analysis of production processes (situation B). Institutions failing to follow this transition will in fact find themselves at a competitive disadvantage. As the Hospital Association of Pennsylvania notes in its "Policy Statement on Health Care Marketplace Initiatives":

"The method of payment for hospital services under the competitive approach is not clear; however, it is assumed that the dominance of cost-based reimbursement will end and that more aggregate (all inclusive) units of payment will emerge and will reflect risk-sharing by all the parties involved. Whereas the present system gives an advantage to those payers who cost-reimburse, it is anticipated that increased competition will have an equalizing effect on prices charged for services rendered. Methods of payment in a competitive system could range from billed charges to negotiated rates to capitation, depending upon the arrangement or contract between the hospital and the health plan. Hospitals will have to develop increased sophistication in the pricing of services in order to bargain effectively in this environment.

The association's policy statement further notes:

"Hospitals which perform well under a more competitive system may be those which:

"(a) Spread the risk by joining forces with other hospitals in arrangement such as multihospital systems.

"(b) Gain more control over circumstances by operating their own competitive health plans.

"(c) Develop other enterprises to support their health care programs; and/or

"(d) Change their utilization patterns as a result of increased competition.

"Horizontal and vertical integration strategies will therefore become increasingly important."

II. THE ECONOMICS OF HOSPITAL FINANCE OR HOSPITAL FINANCE BASED ON PAYMENT FOR THE PRODUCT(S)

In section I of this paper, behavior patterns were said to be able to describe economic rationality—they can describe institutional responses to economic incentives. So, "the economics of hospital finance" can be said to be a matter of behavior. Hospital decisionmakers know how they have behaved in situtation A, that is, in an environment where the economic incentives are to maximize reimbursement for the factors of production. (Recall that the basic economic questions was, "How can I maximize by reimbursement?")

But how will the behavior of hospital decisionmakers change? How will they help to lead their institutions to change behavior as situation B emerges? The "bottom line" still will be a measure of an institution's success and its ability to continue serving its public. How that "bottom line" is attained will begin to change markedly if, in fact, the institution behaves differently, but still in an economically rational manner. Only now the economic behavior increasingly will be one where risks are assumed by the producer, and the basic economic question becomes more and more, "Should I (continue to) produce? "

The effects of these behavior changes, which reflect a response to decisions made about the operating environment of the institution, will continue to be partially reflected in various financial management tools. Traditionally, these tools have conveyed, at least in part, the effectiveness of management's ability to maximize reimbursement primarily from cost-based payers (situation A). In the future these will reflect the ability of management to operate in a generally more price-competitive environment (situation B).

—*Cash flow statements.*—The use of various cash flow statements serves to help document working capital needs and associated costs. Cash inflow and outflow both must be considered. As Berman and Weeks note in their standard text, "The Financial Management of Hospitals":

"The cash inflow stream represents the flow of cash payments to the hospital in return for services rendered. It can be viewed as consisting of two components: A production cycle and an accounts receivable cycle. The timing of cash inflows, i.e., the length of time between the initial production of a service and a receipt of payment for that service, are hence a function of (1) how long it takes to produce the service (production cycle), and (2) how long it takes to receive payment for the service after it is produced (accounts receivable cycle).

"The cash outflow stream represents the flow of payments which the hospital must make in order to obtain labor, supplies, and other items needed to produce services.

"The amount of cash, or the quality of working capital, which must be held is a function of the timing and amount of cash inflows and outflows."

Note well that institutional cash flow has been identified to be dependent in part upon production factors. However, this dependence has not been matched by an economic analysis of the production processes within an institution. Again, the focus has been on reimbursement maximization without a corresponding economic analysis focusing on maximizing efficiency and effectiveness of the production process. As indicated earlier, emerging price competitive conditions will force an expanded analytical focus.

—*Balance sheet.*—Berman and Weeks explain that "a balance sheet depicts the results of a number of financial events and actions at a particular point in time. It shows as of a specific date (point in time) the accepted monetary value of both the hospital's assets and obligations or liabilities. The difference between these two categories of items—assets and liabilities—is the hospital's capital or net worth." As with the cash flow statements, the balance sheet partially reflects management's ability to operate effectively in a reimbursement system dominated by cost-based payers. Similarly, in the future it will reflect the ability of management to operate in a generally more price-competitive environment.

—*Financial ratios.*—Studying relationships between and among individual financial statement items contributes to the assessment of an organization's financial condition and the identification of potential problems in advance so that, when necessary, corrective action can be taken. As one dimension of financial analysis, ratio analysis is one of the most useful financial management tools available to any organization. Ratios help health care institutions document their financial requirements. They help to justify price increases that will enable an organization to meet its full financial requirements. Ratios can assist hospitals in their internal assessment of the ability to assume debt, and they are used externally by lending institutions to determine the debt capacity of potential borrowers. Ratio analysis has helped organizations identify problems well in advance of their becoming critical; it is in fact an important contributor to long-range institutional financial and operational planning.

III. SUMMARY PERSPECTIVE

"Hospital finance based on payment for product(s)"? Yes, indeed, situation B is beginning to emerge within the health and hospital sector. Hospital finance increasingly will be based on payment for the product and if the answer to the basic economic question, "Should I (continue to) produce?" is affirmative, then more economic questions follow and must be addressed.

Economic rationality, or behavior patterns describing institutional responses to economic incentives, then will involve answering questions like:

(1) How should the factors of production be combined most efficiently and effectively?

(2) What are the sizes of the various producing units that an institution can create/maintain such that production economies of scale (and not diseconomies) can be realized wherever possible?

(3) What services should be produced; what should be the areas of institutional product emphasis?

(4) What is the availability of and the potential for utilization of substitutes?

(5) What are the vertical and/or horizontal production integration opportunities?

(6) What are the appropriate relationships between production costs and product price?

(7) What is the appropriate institutional service area regarding various products?

The answers to these and other probing economic questions will serve to describe economic rationality in the future. Moving from situation A to situation B will be a lengthy, evolutionary process and one in which various experimental applications will be tried. Guidelines for some of those applications are suggested in the next section of this paper.

IV. GUIDELINES

Perhaps the best way to examine some of the basic guidelines whose application would help the evolutionary movement from situation A to situation B is to present first a series of comparative statements—the following offers some contrasting system elements:

Current (situation A)

(1) Reimbursement for inputs. (2) No product pricing. (3) Little or no risk by producer. (4) Cost documentation. (5) Little or no production links. (6) Basic economic question: How do I maximize reimbursement? (a) Associated economic rationality questions: None.

Proposed (situation B)

(1) Payment for output. (2) Product pricing. (3) Producer assumes marketplace risk. (4) Economic analysis of production. (5) Production-based links. (6) Basic economic question: Should I (continue to) produce? (a) Associated economic rationality questions: How should factors of production be combined most efficiently and effectively? What are the sizes of the various producing units that an institution can create/maintain such that production economies of scale (and not diseconomies) can be realized wherever possible? What services should be produced; what should be the areas of institutional product emphasis? What is the availability of and the potential for utilization of substitutes? What are the vertical and/or horizontal production integration opportunities? What are the appropriate relationships between production costs and the product price? What is the appropriate institutional service area regarding various products?

The "proposed statements" identify elements which, if applied, would help to develop a more typical economic marketplace in the health and hospital environment. In particular, our recommendations to help create situation B include:

Recommendation 1.—The cost-based reimbursement system should be eliminated, as should the associated cost allocation requirements.

Recommendation 2.—Hospitals should set their own product prices and be "at risk" so that these product prices will be competitive.

Recommendation 3.—Hospitals should create production-based links wherein they are horizontally and/or vertically integrated with other providers (institutional and/or noninstitutional).

Recommendation 4.—Hospitals should create and use the production-based links to provide the basis for formulating various product packages.

Recommendation 5.—Hospitals should market their output.

Recommendation 6.—Hospitals should develop variable product and product payment packages for both patient representatives doing the purchasing and for the patient who is also the direct purchaser.

Recommendation 7.—The product payment packages should create a shared risk structure such that: For the provider, the risk is that the product price set in relation to factor costs will be sufficient to cover these costs and also allow an operating margin. For the purchaser (nonuser), the risk is that the product package is what the end user wants/needs. For the user, the risk is that the appropriate package has been purchased at the best possible price.

Exhibit B

RECOMMENDED IMPLEMENTATION STRATEGY SO THAT PAYMENT FOR HOSPITAL SERVICES WOULD BE STRUCTURED SO AS TO ENCOURAGE EFFICIENCY AND MINIMIZE UNNECESSARY UTILIZATION AND INVESTMENT IN HOSPITAL RESOURCES

The first implementation recommendation is:

Step 1.—The cost-based reimbursement system will be eliminated, as will the associated allocation requirements.

Implementation of this basic change is predicated upon satisfactory demonstration of the following elements:

Step 2.—Producers will calculate utilization characteristics and unit production costs using historical experience. Subsequently, they will estimate cost projections where these projections are in part dependent upon the production links created (see step 3, below).

Step 3.—Producers will create production links, establish product lines, and determine associated product prices.

Step 4.—Government, business, and industry buyers will determine their historical consumption expenses.

Step 5.—These buyers then will define acceptable "health care packages" and acceptable expense ranges for these packages.

Steps 2 and 3 describe implementation actions on the part of the seller/producer, while steps 4 and 5 describe implementation actions taken by the buyer/consumer. Since a marketplace economy is defined as one which is characterized by the interplay of demand and supply forces, a mechanism must be found which creates that interplay. It is suggested here that "third parties" should assume this critical role.

Three mechanisms are described below which would create necessary interplay of demand and supply forces by bringing together buyers and sellers. It is important to note that third parties may include government, Blue Cross plans, commercial carriers, and self-insured business and industry. Further, it is important to recognize that the conditions will have been set for these "third parties" to assume their critical role. How will these conditions have been set?

(a) The cost-based reimbursement systems will have been eliminated.

(b) Producers will have determined costs and utilization characteristics, created production links and product lines, and set prices.

(c) Buyers will have determined consumption expenses, defined acceptable health care packages, and set acceptable health care package expenditure ranges.

With these factors in mind then, the critical "third party" mechanisms for bringing together the buyer and the seller are described in step 6 as Transactions Processes A, B, and C:

Step 6: Transactions process A.—(A.1) The third party (or carrier) works with the buyer to determine appropriate health care packages and subsequently secures contracts from the buyer to purchase the necessary products for these health care packages. (A.2) The producer receives bids from the carriers who now have contracts from the buyers. (A.3) The producer and the carrier then negotiate a package of health care services consistent with the contract.

Transactions process B.—(B.1) The carrier purchases a service package from the producer. (B.2) The carrier markets this service package to potential buyers. (B.3) The buyer negotiates a health care package with the carrier for the consumption of services from the seller(s) with which the carrier has worked.

Transactions process C.—(C.1) The third party (or carrier) works with the buyer to determine appropriate health care packages and subsequently secures contracts from the buyer to purchase the necessary products for these health care packages. (C.2) The carrier receives bids from producers. (C.3) The carrier arranges contracts with producers whose bids best meet the buyer's specifications.

These transactions processes are not mutually exclusive. The carrier could in fact assume both roles simultaneously and market to different segments within the industry. The critical factor is that the carrier assumes a pivotal role in creating and coordination the interplay between demand and supply, i.e., between buyer and seller.

If these implementation steps are acceptable, what remains is a determination of what each of these steps requires in order to be realized. Having developed and analyzed these steps, it is my opinion that the realization requirements for each of them can best be identified via the following assignments:

(a) *Step 1.* Elimination of the cost-based reimbursement system: Government would have to take the lead in identifying the elements required to realize this basic step.

(b) *Steps 2 and 3.*—Producer calculations of utilization characteristics and unit production costs, creation of production links, establishment of product lines and associated product prices: The elements required to realize these two implementation steps can best be set forth by a hospital representative.

(c) *Steps 4 and 5.*—Buyer determination of consumption expenses, delineation of acceptable health care packages, and determination of acceptable health care package expenditure ranges: Business and industry representatives should specify those elements required for realization of these two implementation steps.

(d) *Step 6.*—Creating an interplay between buyers and sellers via transactions processes A, B, and C: Insurance industry representatives should take the lead in identifying elements required for this implementation step.

(Note: See graphic representation of implementation Steps 2 to 6.)

1. Seller/producer determines historical or anticipated production cost, then, unit prices are set.

2. Buyer/consumer determines historical consumption expense, then, unit prices are set

3. Carrier then assumes a central role in a transactions process.

Process A: Carrier markets to buyers and secures contracts. Producer receives bids from carriers who have buyer contracts. Producer and carrier negotiate package. Or

Process B: Carrier purchases a service package from producer. Carrier markets the "care package" it has purchased (from producer) to potential buyers. Buyers negotiate package with carrier. Or

Process C: Carrier markets to buyers and secures contracts. Carrier receives bids from producers. Selected producers negotiate contract with carrier.

Senator HEINZ. I note that in exhibit B, you do detail the implementation strategy, so that the payments for hospital services would be structured to encourage efficiency and minimize unnecessary utilization and investment in hospital resources.

You indicated that this is only part of the set of implementations that the Hospital Association of Pennsylvania will be developing. When do you envisage the rest will be developed and available?

Mr. ACKROYD. They are currently being developed, and I would say that within the next 2 to 4 weeks, the next phase of the implementation strategy will be completed, that phase. The overall strategy will not be, but when you work with a time frame that the Governor sets, you try to respond—March 19.

Senator HEINZ. Let me, first of all, congratulate you on what you are doing. It is very serious work, it is very important work. Let me encourage you at the same time to press ahead because yesterday, Secretary Schweiker, when he was before my Senate Finance Committee and testifying on what the administration plans to do with respect to medicare and medicaid, in addition to the budgetary suggestions that he has made, indicated that the administration plans, by regulation, to move rather quickly toward what you and I would call a prospective reimbursement system, and that they might publish such regulations within the next month or two. So to the extent that what you are proposing is a superior model, I hope that it will be available for both our and the Secretary's thinking.

I am advised that Senator Cohen has no further questions.

I would invite any additional comments that either of you have at this time.

Mr. Ackroyd, do you have any additional comments?

Mr. ACKROYD. Just an observation on the discussion today, and that is, I heard for the entire morning the bleak picture that has been painted about fraud and abuse. While I appreciate that that condition does exist in all States, I think that we could deliberate forever on that situation, those conditions, and I would prefer to move toward what are the positive things we can do as providers, consumers. business, government, all of us working together, to create a more efficient and effective system.

Senator HEINZ. Let me tell you I agree totally. The problem has been that in spite of the fact that you and Mr. Hoff and many others favor a competitive model—and it has been several years since the discussions of how you reach a competitive health care system have been taken seriously—the fact remains, we are no closer today than we were 3 or 4 years ago. The purpose of this hearing is in part to motivate everybody who is concerned about health care—everybody in Washington, whether they are in the executive branch or the legislative branch, or in the health care industry about the fact that the present system is deeply flawed; there is a body of evidence that suggests, although not everybody agrees, that it cannot be patched up and sustained, and that rapid movement to a better system, which we label competition, must be accelerated so it is a reality rather than simply rhetoric. That is one of the key purposes of this hearing, and you are quite right, that is why we are here.

Mr. Hoff, any further comments?

Mr. HOFF. Senator, I am glad, for that reason, that you have held these hearings. I think that your report of what Secretary Schweiker apparently testified to yesterday testifies to the need, really, for the Congress, and I hope also for the administration, to get going very quickly on competition. I am concerned that prospective reimbursement may come in over and defer the consideration of competition by its very existence, and I hope that will not happen.

Senator HEINZ. The administration is trying to determine what kind of a competitive model they are going to send down here. That decision, indeed, is supposed to be made today. Secretary Schweiker is supposed to fly out to the west coast today and tomorrow and tell someone from the west coast about it. So we will find out. I hope it is a good decision.

If there are no further comments, further questions will be submitted to you for the record. Let me thank you both, particularly Ted Ackroyd, who has come down from my home State of Pennsylvania. Let me compliment him again on the fine work that he and the Hospital Association are doing. Mr. Hoff, let me compliment you as well for your very thoughtful testimony.

Mr. ACKROYD. Thank you, Mr. Chairman.

Mr. HOFF. Thank you, Senator.

Senator HEINZ. Thank you, gentlemen.

This hearing is adjourned.

[Whereupon, at 12:25 p.m., the committee adjourned.]

APPENDIX

MATERIAL RELATED TO HEARING

A REVIEW OF THE BUSINESS RELATIONSHIPS OF COMMUNITY HOSPITAL OF THE VALLEYS

This report is made pursuant to contract HHS-100-80-0119. The amount charged to the Department of Health and Human Services for the work resulting in this report is $____________. The names of the persons, employed or retained by the contractor, with managerial or professional responsibility for such work, or for the content of the report, are as follows:

Clinton Armstrong, Contract Manager

Robert L. Clements, Project Director

W. F. "Stan" Witten, Supervising Special Investigator

Office of the State Controller

State of California

EXECUTIVE SUMMARY

The Controller's Office of the State of California in cooperation with the Department of Health and Human Services, Office of the Inspector General undertook a project to study hospital corporate structures. The results of our inquiry are detailed in the accompanying report.

The project was originally conceived to audit and investigate the corporate structures of five California hospitals over a period of two or three years. The Controller's staff had planned to select different types of structures that would provide a sample large enough to permit the development of broad conclusions. Unfortunately, the project's scope was limited to a single facility because of funding limitations. However, the staff believes the work can and should continue so long as the Medicare and Medi-Cal programs utilize cost reimbursement systems that permit structural abuse.

Although the project was limited in scope, we believe it was successful in pinpointing and documenting serious problems characterized by the corporate structure of Community Hospital of the Valleys, a small 36 bed facility in Perris, California. The report addresses in detail the facility's history and corporate structure. We believe the report accurately communicates the inner workings of the hospital and the associations with the major contractors.

Much of our work took advantage of previous audit work performed by Blue Cross of Southern California and the Audits Section of the Department of Health Services. In short, we used their work as a platform to conduct a detailed audit and investigation. Our findings have been shared with these groups throughout the project as a matter of courtesy and to permit the effective management of the Medicare and Medi-Cal programs.

We found that Perris Valley Scientific, Inc. and Medical Environments, Inc., the ancillary and management services contractors, exercised control over Community Hospital of the Valleys at the time of the hospital's formation and through this control obtained their contracts. We determined that Community Hospital of the Valleys, Perris Valley Scientific, Inc. and Medical Environments, Inc. were related organizations and that the relationships were not reported to Medi-Cal or Medicare. The hospital claimed approximately $5,789,000 in costs for reimbursement from Medi-Cal and Medicare due to transactions with the management and ancillary services contractors. Currently, the State is carrying a $563,000 Medi-Cal receivable due to audit adjustments to the first two of the hospital's four-and-a-half years of operations. The audits of the last two-and-a-half years have not yet been completed. The completed audits are currently under appeal. We recommend that the Department of Health Services continue to pursue recovery of currently outstanding Medi-Cal audit adjustments and obtaining the cost records of the management and ancillary services contractors.

We also found what we considered to be improper actions on the part of the contractors and the hospital. We recommend that the Department of Health Services request the Attorney General to review the report and the related documentation to determine if State laws have been violated.

We also recommend that the Department of Health Services seek the establishment of penalties for hospitals which fail to report major contracts with related entities and the requirement of competitive procedures by hospitals to select major services contractors.

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CHAPTER I

INTRODUCTION

This report presents the results of the Controller's project to audit the corporate structure of Community Hospital of the Valleys, a 36 bed facility in Perris, California.

The report is divided into chapters. The first chapter presents introductory material and a summary of the report. The second chapter briefly discusses the selection process used to identify Community Hospital of the Valleys. The third chapter provides overall background material on the hospital and its contractors. Chapter IV through Chapter VI present the major findings of the audit and Chapter VII presents a summary of the findings and recommendations.

THE CONTROLLER'S OFFICE UNDERTOOK A PROJECT TO STUDY HOSPITAL CORPORATE STRUCTURES

The Controller's Office as part of its continuing program to ensure the appropriateness of state disbursements undertook a project for the Department of Health and Human Services to study hospital corporate structures. The project was designed to test the theory that certain types of corporate structures artificially inflate the costs of Medicare and Medi-Cal through abusive contracting procedures that cause the improper disbursement of government funds.

The project was funded at a level that permitted the audit of a single California hospital. Although it would have been preferable to study several different facilities, the project's scope had to be limited to a single hospital because of funding limitations. With this limitation in mind, the project was developed as a prototype to test new approaches to auditing hospital corporate structures. The Controller's staff did not invent new techniques, but utilized accepted auditing and investigative procedures. The difference being that the procedures were blended together to take full advantage of both disciplines and sufficient time was budgeted to pursue information in detail.

SCOPE

The project was divided in three phases. The first phase consisted of developing background material, surveying applicable regulations, data bases and the work performed by other audit groups. The second phase focused on developing and implementing a process to select hospitals with potentially abusive corporate structures. This resulted in the selection of Community Hospital of the Valleys based on the facility's cost profile and corporate structure. The third phase involved auditing and investigating the hospital's corporate structure and the relationships with the major contractors.

The audit work was designed to identify and analyze the corporate structure of Community Hospital of the Valleys and the costs associated with the structure. The work was performed by examining the hospital's major contracts and the relationships between the major contractors and the hospital's governing board and management structure.

Our examination was a special study of the corporate relationships of Community Hospital of the Valleys and the entities with which it contracted for services. Our examination did not include tests of the accounting records of the entity under review. Our review did include those tests and auditing procedures we considered necessary under the unique circumstances of this assignment.

The audit work stressed the impact of the hospital's corporate structure on the costs incurred by the Medicare and Medi-Cal programs. Both programs utilize a cost reimbursement system whereby they share in the costs of running hospitals in rough proportion to their respective shares of the costs of rendering care to Medicare and Medi-Cal patients. In particular, the audit attempted to determine if Medicare and Medi-Cal experienced excessive costs as a result of the corporate structure of Community Hospital of the Valleys. We were however unable to obtain the cost records of the hospital's contractors and could not fulfill this objective.

CHAPTER II

SELECTION OF THE AUDITEE

A formal selection process was developed and implemented to identify California hospitals that had potentially abusive corporate structures. The process utilized the data base of the California Health Facilities Commission as well as the audit files and expertise of the Medicare and Medi-Cal auditors. The process generated a list of audit candidates from which Community Hospital of the Valleys was chosen as the primary auditee.

THE PROCESS

The Controller's staff designed a sophisticated process to screen records of the California Health Facilities Commission to identify hospitals with potentially abusive corporate structures. The process was constructed on the general theory that abusive structures exhibit high cost patterns that can be detected in selected cost centers.

The selection process was designed as a filtering mechanism to rapidly identify a manageable number of facilities that could be researched in depth using manual techniques. This was accomplished by screening data on 555 of California's hospitals to identify those facilities with a high dependence on leasing arrangements to provide plant and equipment. The leasing criterion was selected because the Controller's staff considered it to be a strong indicator of possibly abusive corporate structures.

The application of the leasing criterion identified 72 hospitals located throughout the state. This was still too large of a population and was reduced to a final size of 39 hospitals by selecting those facilities located in three health planning areas in southern California. The planning areas were selected because of their heavy concentration of leased facilities and included the counties of Los Angeles, Orange, Mono, Inyo, San Bernardino and Riverside.

The 39 hospitals were analyzed in a two step process to select a primary audit candidate. The first step was to prepare rankings of the 39 hospitals based on cost data. The rankings provided the Controller's staff with the first strong indications as to the primary audit candidates. The second step was a review of the audit files of Medicare and Medi-Cal.

California requires all hospitals to disclose financial data to the California Health Facilities Commission. This data is used by the Commission to produce per unit cost rankings for the various hospital cost centers. This unit cost information was used by the Controller's staff to build profiles for the 39 hospitals. These profiles were built in two phases.

The first phase was general in nature and simply ranked the hospitals by the number of cost centers that exceeded the 90th percentile for all California hospitals as established by the Health Facilities Commission Cost Data. All cost centers were included as originally reported by the Commission. Community Hospital of the Valleys ranked second in one year and third in the other. The highlights of this first ranking process are summarized in Table 1 and further detailed in Table 2.

The second phase was a specific analysis and ranked the hospitals based on per unit costs of selected cost centers. The selected centers were chosen because of their potential to identify abusive corporate structures. The results of this specific analysis also ranked Community Hospital of the Valleys very high. Seven of the hospitals fourteen cost centers that exhibited extremely high costs were directly linked to the facility's major contractors. The results of this analysis are summarized in Table 3.

The review of the Medicare and Medi-Cal audit files was used to determine if a close correlation existed between the hospital's high costs and the ancillary and management services providers. This work concentrated the auditors attention on Community Hospital of the Valleys and showed a strong relationship between high costs and the contractual services. During this review we also received strong recommendations by the Medi-Cal auditors of the Division of Health audits for selection of Community Hospital of the Valleys as the audit candidate.

As a result of the ranking process, the audit file review and the recommendations of the Medi-Cal auditors, Community Hospital of the Valleys was selected as the auditee.

Table 1

Comparison of the Number of Cost Centers With Per Unit Costs Exceeding the 90th Percentile

Entity	Number of Cost Centers Exceeding 90th Percentile 4th Year[a]	Number of Cost Centers Exceeding 90th Percentile 5th Year
Community Hospital[b] of the Valleys	10	14
Highest ranked facility	14	15
Lowest ranked facility	3	3
Average for the 39 hospitals	6.76	7
Median for the 39 hospitals	6	6

---

[a] To compute the per unit cost percentiles, the California Health Facilities Commission develops data for the 3rd year reports and compares that to the 4th year. The same approach is used for the 5th year data which is based on percentiles computed using 4th year data. The 4th year includes reports covering fiscal years ending between June 30, 1978, and June 29, 1979. The 5th year covers years ending between June 30, 1979, and June 29, 1980.

[b] Community Hospital of the Valleys ranked third in the 4th year and second in the 5th year.

Table 2

Listing of Cost Centers for Community Hospital of the Valleys That Exceeded the 90th Percentile for 5th Year Data a/

Cost Center	Per Unit Costs Community Hospital	90th Percentile	Contracting b/ Entity
Medical/Surgical Acute	$ 75.23	$ 67.66	-------
Anesthesiology	2.18	1.32	-------
Clinical Lab	11.61	.94	Perris Valley Scientific, Inc.
Pulmonary Function	57.96	11.57	Perris Valley Scientific, Inc.
Electrocardiology	34.45	20.43	Perris Valley Scientific, Inc.
Diagnostic Radiology	37.51	6.47	Perris Valley Scientific, Inc.
Inhalation Therapy	40.06	15.93	Perris Valley Scientific, Inc.
Physical Therapy	24.89	13.75	Perris Valley Scientific, Inc.
Printing and Duplicating	67.57	34.50	-------
Security	349.82	189.66	-------
Communications	537.63	472.28	-------
Hospital Administration	3,694.95	2,819.46	Medical Environments. Inc.
Personnel	304.99	271.22	-------
Inservices Education	64.36	32.24	-------

---

a/ The percentile rankings were developed by the California Health Facilities Commission based on 4th year reported data. The Commission's 4th year includes reports for hospitals with fiscal years ending between June 30, 1979, and June 29, 1980.

b/ We believe these contractors to be related entities.

Table 3

The Per Unit Cost Rankings For Community Hospital of the Valleys

Cost Center or Indicator	4th Year[a/] [b/]	5th Year[b/]
Ancillary Costs as a Percentage of All Costs	1st	1st
Medical/Surgical Acute	12th	4th
Pharmacy	11th	10th
Electrocardiology	1st	1st
Anesthesiology	2nd	1st
Pulmonary Function	6th	2nd
Inhalation Therapy	1st	2nd
Clinical Lab	7th	1st
Diagnostic Radiology	26th	1st
Hospital Administration	5th	7th
Leases	20th	17th

---

a/ The footnote in Table 1 explains the designation of the 4th and 5th years.

b/ Ranking of the 39 hospitals selected for review with per unit costs on designated cost centers.

CHAPTER III

COMMUNITY HOSPITAL OF THE VALLEYS

BACKGROUND

Perris, California, has been the site of four unsuccessful hospitals. Although the owners, the types of corporate structures and the hospital's name have changed, the result has always been the same. In all cases, the hospitals' final days were spent in bankruptcy court as is now the case for Community Hospital of the Valleys.

The financial failures of the hospitals have not only effected the City of Perris, but also have effected the Medi-Cal program. Each time the hospital bankrupted, the State was left with a receivable by virtue of its inability to collect outstanding audit adjustments. In the case of Community Hospital of the Valleys, the State of California is currently carrying a receivable for $563,000 which represents audit adjustments for just two of the hospital's four fiscal years. The problem also exists with the other bankruptcies. The amount carried as a receivable by the State of California from the previous hospitals is $98,000.

The first hospital licensed was Perris Valley Community Hospital which opened for business in April of 1972. The facility was owned and managed by a general partnership composed of five physicians, all of whom were residents of Perris, Riverside or surrounding communities. Although the physicians owned the hospital, they did not construct or own the hospital building. The building was built by an investor from Los Angeles named Allen Tatkin.

The partnership operated the facility until February of 1975 when the physician partnership went into bankruptcy and the facility's license was transferred to Lakeview Hospital, Inc., a nearby hospital that was a subsidiary of Universal Medical Systems, Inc. Universal Medical Systems, Inc. was a small chain that operated two other hospitals and one nursing home.

Universal Medical Systems, Inc. managed the hospital for 16 months until June of 1976 when Lakeview Hospital, Inc. sold its interests to an Oregon corporation, L & J Investments, Inc. Universal Medical Systems, Inc. later filed for bankruptcy. The new owner, L & J Investments, Inc., operated the facility for only five months, and in October of 1976, the hospital closed its doors.

From the standpoint of the State of California and the Medi-Cal program, the net result of the hospital's first five years was an outstanding audit adjustment of $98,000. The adjustment was based on the cost settlement audits performed by Medi-Cal.

The Community Hospital of the Valleys was organized during the period December 8, 1976 through December 29, 1976. During this period the hospital was incorporated as a not-for-profit entity and the name was changed from Perris Valley Community Hospital to Community Hospital of the Valleys. Also during this period the hospital's directors and officers were chosen, its major contracts negotiated, and long-term financing arranged.

During the same 22-day period two of the hospital's major contractors were also organized. They were Perris Valley Scientific, Inc., the ancillary contractor and Medical Environments, Inc., the management contractor.

INCORPORATION OF THE HOSPITAL

On December 8, 1976 the hospital was incorporated in California as a not-for-profit corporation under the name Perris Valley Medical Center. The articles of incorporation were amended on December 31, 1976 to change the name to Community Hospital of the Valleys. The incorporating minutes stated that the specific and primary purpose of the corporation was to operate a not-for-profit hospital for charitable purposes. The corporation was to be organized as a 501(c)(3) tax exempt organization under the provisions of the Internal Revenue Code.

Stephen Miller, and two secretaries in Miller's law firm (Rubin and Miller) served as the first directors of the hospital's governing board. Their appointments became effective as of the incorporation date of the hospital on December 8, 1976. The secretaries retained their positions as directors only long enough to span the time between the hospital's incorporation and the first board meeting. On December 27, 1976 the hospital's first formal board meeting was held. At this meeting Miller's secretaries were removed from the board and Dr. Ludlow Creary and Dr. Linares Johnson were appointed.

Although the minutes do not directly state that Howard Kaatz was named a director, they do show that Kaatz was named Vice-President of the corporation and the corporation's by-laws state that all officers are members of the board of directors. At this same board meeting Stephen Miller was named chairman of the board and president of the hospital corporation and Ludlow Creary was named secretary. At a subsequent board meeting, on January 7, 1977, Linares Johnson was named corporate treasurer. Stephen Miller appeared to be the dominant member of the hospital's governing board during the hospital's formative stages. The board's composition changed considerably during the first six months but Stephen Miller remained as chairman of the hospital's board and president of the hospital corporation.

The minutes of the December 27, 1976 meeting show the hospital's officers were authorized to execute agreements with Perris Valley Scientific, Inc. and Medical Environments, Inc. Authorization was also given to borrow $210,000 from Perris Valley Scientific, Inc. and to execute a security agreement to secure the loan. The effect of the authorizations was to approve all of the hospital's major contracts. The land, building, and equipment leases were not mentioned, but had already been signed on December 22, 1976.

The end of the hospital's formation period was December 29, 1976. On this date the promissory note and the security agreement covering the $210,000 loan were executed. With the hospital incorporated, the leases signed, the other major contracts authorized and the long term financing obtained, there was little left to do except to file for an operating license. This was accomplished on December 31, 1976, and the hospital opened its doors for business on January 10, 1977.

The hospital's corporate structure is presented in Table 4 and the important events of the hospital's formation are summarized in Table 5.

Table 4

Organization Chart

Community Hospital of the Valleys

January 1, 1977

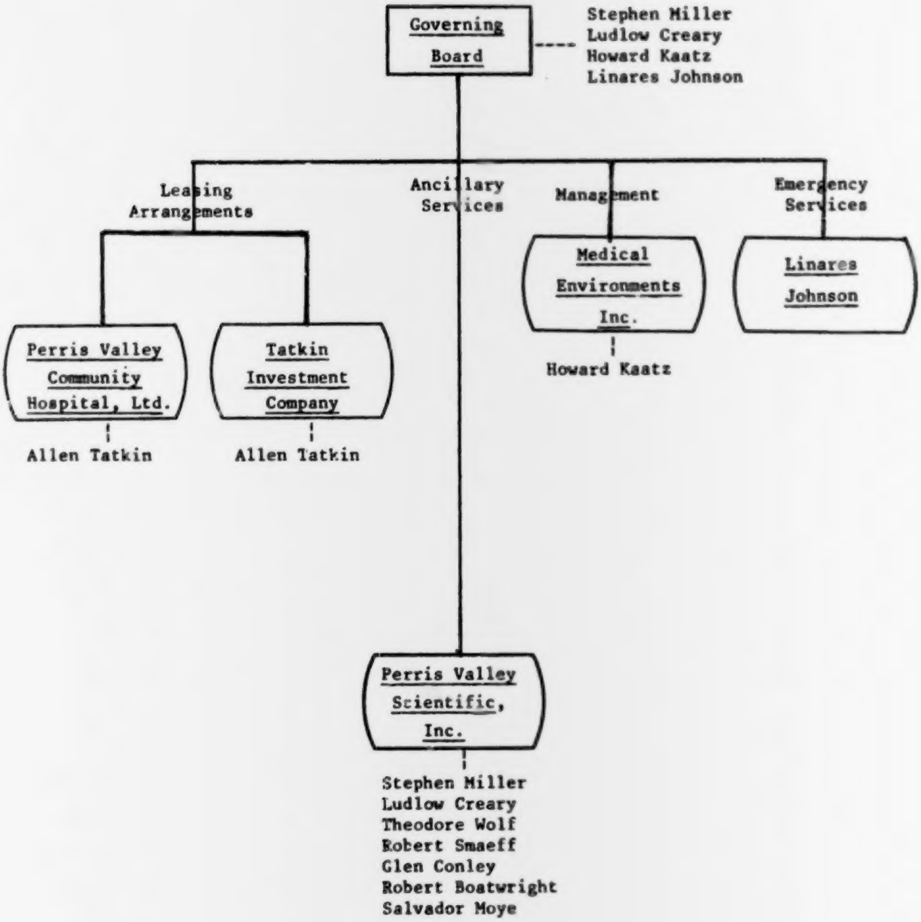
Governing Board
Stephen Miller
Ludlow Creary
Howard Kaatz
Linares Johnson
Leasing Arrangements
Ancillary Services
Management
Emergency Services
Medical Environments Inc.
Howard Kaatz
Linares Johnson
Perris Valley Community Hospital, Ltd.
Allen Tatkin
Tatkin Investment Company
Allen Tatkin
Perris Valley Scientific, Inc.
Stephen Miller
Ludlow Creary
Theodore Wolf
Robert Smaeff
Glen Conley
Robert Boatwright
Salvador Moye

Table 5

Important Events in the Formation of Community Hospital of the Valleys

1976

October 10	Perris Valley Community Hospital closed it doors.
December 8	Stephen Miller incorporated Community Hospital of the Valleys and Perris Valley Scientific, Inc.
December 20	Perris Valley Scientific, Inc. held its pre-incorporation meeting and first formal meeting. The corporation authorized its officers to ute the ancillary contract with Community Hospital of t. alleys and also to loan the hospital $210,000.
December 21	Howard Kaatz's management firm, Medical Environments, Inc. was incorporated.
December 22	The hospital executed the real property lease with Perris Valley Community Hospital, Ltd. and the equipment lease with Tatkin Investment Company, both entities of Allen Tatkin. Allen Tatkin granted to Perris Valley Scientific, Inc. the option to purchase the hospital real property.
December 27	Community Hospital of the Valleys held its first formal board meeting. The board authorized the officers to execute the ancillary contract with Perris Valley Scientific, Inc. and to borrow $210,000 from the corporation. Authorization was also given to contract with Medical Environments, Inc. for management services.
December 29	The promissory note and security agreement for the $210,000 loan were executed.
December 31	Community Hospital of the Valleys applied for its operating license from the Department of Health Services.

1977

January 10	Community Hospital of the Valleys opened its doors.

THE ANCILLARY SERVICES CONTRACTOR

The ancillary services contractor was Perris Valley Scientific, Inc. On December 8, 1976 Stephen Miller filed documents to incorporate Perris Valley Scientific. On December 20, 1976 the corporation held what was termed its pre-incorporation meeting in Stephen Miller's Beverly Hills law office. The proceedings of this meeting were recorded in a document entitled the "Pre-incorporation Agreement". This agreement discussed not only the internal matters of Perris Valley Scientific, Inc., it also discussed in detail the major contracts and leases that Community Hospital would execute. In particular the agreement specified the following:

-- Perris Valley Scientific, Inc. was to execute an agreement to provide Community Hospital of the Valleys with all of its ancillary services.

-- The corporation was to loan $210,000 to the hospital and to execute a security agreement to protect the corporation's creditor standing.

-- The hospital was to enter agreements with entities controlled by Allen Tatkin to lease the hospital land, building and equipment.

-- The hospital was to retain the services of Howard Kaatz's firm, Medical Environments, Inc., to provide management services. The shareholders as well as the hospital agreed that the $210,000 loan was conditioned on the use of Howard Kaatz's services.

Perris Valley Scientific, Inc., also held the first formal meeting of its board of directors on December 20, 1976. The most important item in the board minutes was the resolution authorizing the corporation to execute the ancillary agreement with Community hospital. The minutes also show approval was granted to designate certain shareholders as the subcontractors to provide the hospital with ancillary services on behalf of PVS. Table 6 identifies those shareholders and the services they were to provide as well as their percentage of ownership in Perris Valley Scientific, Inc.

Table 6

Shareholders of Perris Valley Scientific, Inc.

Subcontractors of Ancillary Services	Service	Shares	Percentage
Robert Smaeff	pharmacy	1,500	28.6
Glen Conley	respiratory therapy pulmonary lab nuclear medicine	750	14.3
Robert Boatwright	clinical lab	875	16.7
Salvador Moye	clinical lab	875	16.7
Other Shareholders			
Stephen Miller		625	11.9
Dr. Ludlow Creary		375	7.1
Theodore Wolf		250	4.8
		5,250	

THE MANAGEMENT SERVICES CONTRACTOR

On December 21, 1976 Howard Kaatz's management firm Medical Environments, Inc. was incorporated. The firms first contract was an agreement that could last 30 years with Community Hospital of the Valleys. This contract was authorized by the hospital's Board of Directors at their December 27, 1976 meeting and provided Howard Kaatz with the authority to manage the hospital's day-to-day affairs. This contract also resulted in Howard Kaatz also having control over the hospital's finances due to a lack of monitoring of his activities.

THE FACILITIES AND EQUIPMENT LESSOR

Community Hospital of the Valleys leased the building, land, and equipment from entities controlled by Allen Tatkin. Allen Tatkin's firm, Hospital Finance Corporation, constructed the hospital building in 1971 and 1972 and retained ownership throughout the four attempts to operate the facility. The hospital land was originally owned by one of the physicians who formed the general partnership that first managed the hospital. The land was subsequently acquired by Allen Tatkin during the first bankruptcy.

Hospital Finance Corporation was incorporated in 1957 for the purpose of constructing a hospital. Since we have not reviewed the records of this corporation, we are not familiar with the inner workings of the firm. However, our research showed that the corporation began construction of the hospital building in Perris in 1971 and completed construction in 1972.

Hospital Finance Corporation has always maintained ownership of the building even though the facility was built for the physician partnership that was the original operator of the hospital. However, the corporation did not own the land until it was purchased in the hospital's first bankruptcy.

Allen Tatkin served as president of Hospital Finance Corporation during the entire life of Community Hospital of the Valleys and our research identified Tatkin as being president as early as 1971. Tatkin was also listed as one of the corporation's three directors in the incorporation documents filed in 1957.

The property lease was a 20-year contract that was divided into an initial term of 5 years and three 5-year options that could be exercised solely by the lessor. The initial monthly rent was $6,000 per month, but this was later raised in increments to the level of $10,500 per month.

The real property lease was executed on December 22, 1976, when Stephen Miller was president of the hospital's governing board and the only functioning director. The lease was written to grant the lessor the exclusive rights to renew the arrangement after the initial term. All operating costs such as taxes and insurance were assigned to the hospital and made part of the reimbursable cost pool for Medicare and Medi-Cal. The hospital accepted the property without any warranty as to its serviceability.

In a another development, Hospital Finance Corporation granted to Perris Valley Scientific, Inc., the ancillary services contractor, the option rights to purchase the real property. This option was granted for the sum of $10. The hospital was obligated to pay rent at an initial level of $72,000 per year, but no equity in the property and no purchase rights were acquired.

The equipment lessor, Tatkin Investment Company, was incorporated on March 15, 1974 to lease personal property. Allen Tatkin was listed as the corporations chief executive officer and president. The hospital also entered a number of smaller leases with Tatkin Investment Company, but these leases were not executed during the formation of Community Hospital of the Valleys and consequently are not dealt with in this report. The equipment lease was executed on December 22, 1976. The lease covered seven years and was automatically renewable for one year terms. The rent was $5,000 per month. All operating costs were assigned to the hospital and the hospital accepted the equipment without any warranties.

CLOSING OF THE HOSPITAL

As a result of a number of deaths at the hospital, the Riverside District Attorney raided the hospital's files on April 23, 1981 and seized the medical records of 24 patients. The raid initiated an investigation that dominated headlines in California and received national attention. At the date of this report, the District Attorney is continuing his investigation.

The investigation of the 24 deaths and the attending circumstances caused the Department of Health Services to review the hospital to determine the status of its operating license. The Department suspended the hospital's license based on a finding the facility was not in compliance with several licensing requirements. The hospital was served with the suspension on May 12, 1981, and was instructed to transfer its patients and to close its doors. On May 13th the final patient was transferred and the hospital locked its doors.

On May 7, 1981, Perris Valley Scientific, Inc. in concert with the hospital building and equipment lessors filed an involuntary bankruptcy petition under Chapter VII of the federal bankruptcy laws. The hospital in response filed a Chapter XI petition which took precedence over the earlier filing.

On July 15, 1981, the federal bankruptcy court held an auction to sell the hospital's assets which for the most part was the facility's license. In August, the court awarded the assets to the highest bidder, a consortium of Golden Triangle Medical Center, Inc. and Advanced Health Systems, Inc. The consortium in separate arrangements purchased the hospital real property and equipment and plans to refurbish the facility and reopen in late 1981.

From the standpoint of the Medi-Cal program, the hospital is again the source of outstanding audit adjustments that will be difficult to collect. Based on audits performed for 1977 and 1978, the hospital already owes Medi-Cal $563,000. The final amount of the audit adjustments may be reduced in the appeals process, but the State still stands to lose a considerable sum of money from this period. The Medi-Cal auditors are currently preparing adjustments for 1979 and 1980 and eventually must audit the first five months of 1981. These audits will certainly add to the amount owed the State.

CHAPTER IV

COMMUNITY HOSPITAL OF THE VALLEYS AND PERRIS VALLEY SCIENTIFIC, INC. WERE RELATED ORGANIZATIONS

This chapter focuses on the relationship of Perris Valley Scientific, Inc. with the Community Hospital of the Valleys in an attempt to determine if they were related organizations. We have focused on the corporate structures of the hospital, the ancillary services contractor and the roles played by certain individuals associated with both the hospital and contractor in making the relatedness determination. The determinations in this and the subsequent chapter were guided by the following questions which restate the substance of the related organization regulation.

- Did the contractors have the opportunity to exercise control over the hospital through interlocking relationships?
- Did the terms and execution of the contracts between the hospital and the contractors reflect arrangements that were unfavorable to the hospital and the apparent result of "sweetheart" negotiations?

In our opinion this opportunity existed, was exercised and resulted in contracts which were unfavorable to the hospital.

THE RELATED ORGANIZATION REGULATION

The related organization regulation is designed to identify and eliminate excessive costs resulting from transactions between hospitals and contractors who are not negotiating at arms length. In brief, the regulation attempts to deal with the problems of "sweetheart" contracts and corporate structures that attempt to pyramid costs and profits.

The regulation governing related organizations is stated in Section 405.427 of Title 42 of the Code of Federal Regulations. Although the language of the regulation is rather straightforward, the application and interpretation of the basic principle is not. Few reimbursement issues have been so thoroughly litigated. No attempt is made to discuss the ins and outs of all the issues that bear on the question of related organizations. In general, this is unnecessary since the facts of the individual case govern as to whether the regulation applies. However, we will discuss the basic language of the regulation.

The regulation defines organizations to be related if common ownership or control exists. In essence, these are the tests of relatedness. The basic principle and definitions of the regulation are presented below.

> (a) Principle
>
> Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.
>
> (b) Definitions
>
> (1) Related to provider. Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.
>
> (2) Common ownership. Common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.
>
> (3) Control. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

Normally the result of such a finding is that the hospital's allowable costs are limited to the costs of the related supplying organization. From an audit standpoint, this determination is made either by securing financial statements from the supplying organization or performing an audit to determine the actual costs. By whatever means the costs are determined, the costs of the supplying organization are substituted for the charges made to the hospital; the objective is to eliminate the supplier's profits. Hospitals are currently required to disclose material transactions with related entities as a portion of their annual cost reports to the Department of Health Services. Community Hospital of the Valleys indicated that they were not dealing with any related entities.

OPPORTUNITY FOR CONTROL

A number of different interlocks existed which provided Perris Valley Scientific, Inc. with the opportunity to exercise control over the hospital when the major contracts were negotiated. These interlocks are summarized below and discussed in detail in the ensuing pages.

- Two of the hospital's four directors were shareholders in Perris Valley Scientific, Inc.
- Stephen Miller served simultaneously as legal counsel for the hospital and Perris Valley Scientific, Inc.
- The shareholders of Perris Valley Scientific, Inc. served as the de facto governing board of the hospital.
- The $210,000 loaned to the hospital by Perris Valley Scientific, Inc. was executed with a restrictive security agreement.

- Hospital Directors Were Shareholder's in Perris Valley Scientific, Inc.

As detailed previously, in Chapter II, the governing board which committed the hospital to the master ancillary services contract on December 27, 1976 was composed of four directors, two of whom were shareholders in Perris Valley Scientific, Inc. The two were Stephen Miller and Ludlow Creary. The same relationships existed on January 1, 1977, the date the contract was signed.

The contract was executed by four individuals, all of whom were shareholders in Perris Valley Scientific, Inc. Stephen Miller and Ludlow Creary signed for Community Hospital of the Valleys. Robert Smaeff and Robert Boatwright signed on behalf of the corporation. This created a situation in which shareholders of Perris Valley Scientific, Inc. were on both sides of the same transaction.

- Stephen Miller Acted as Counsel for the Hospital and Contractor

The Beverly Hills law firm of Rubin and Miller, Stephen Miller's firm, served simultaneously as legal counsel for the hospital and Perris Valley Scientific, Inc. Our research did not detect an attorney other than Miller who performed any of the contract negotiations work for the hospital or Perris Valley Scientific, Inc. By being counsel for both entities, Miller was able to direct all the significant legal matters pertaining to the major contracts and the corporate structures. The firm of Weissburg and Aronson was also retained by the hospital, but its work was limited to managing disputes with Medicare and Medi-Cal.

In the role of legal counsel, Stephen Miller incorporated both Perris Valley Scientific, Inc. and Community Hospital of the Valleys. He also organized the corporate structures of both entities and probably prepared and negotiated the master ancillary contract and did sign the contract for the hospital. Miller's tenure as counsel began with the very origins of both entities and extended until March of 1981 when Miller resigned from the hospital board and threatened to force the hospital into bankruptcy.

A simple approach to examining Stephen Miller's role is to review the parallels between the corporate formations of Perris Valley Scientific, Inc. and Community Hospital of the Valleys.

Miller organized the two entities identically. Both were incorporated on the same date, December 8, 1976. The incorporating documents were filed back to back as demonstrated by the filing numbers assigned by the Secretary of State's Office. The articles of incorporation for the hospital were assigned the filing number of 789177 and the articles for Perris Valley Scientific, Inc. were assigned the number of 789178.

The two entities were incorporated with the same board of directors composed of Stephen Miller and his two secretaries. In the case of Perris Valley Scientific, Inc., Miller removed himself and the two secretaries from the board on December 20, 1976. However, in the case of the hospital, Miller retained his board membership and was even named president. The two secretaries were removed from the hospital board at the first formal meeting.

The minutes of Perris Valley Scientific, Inc.'s pre-incorporation agreement show that the firm of Rubin and Miller was appointed as the corporation's legal counsel. A review of minutes and documents of the hospital does not pinpoint a particular reference to the law firm being retained, however, it is clear from the filing of incorporation documents, the preparation of contracts and related correspondence that Miller was the hospital's attorney.

- The Shareholders of Perris Valley Scientific, Inc. Served as the DeFacto Board of the Hospital

The minutes of the initial meetings of Perris Valley Scientific, Inc. show the shareholders were discussing plans and making arrangements that affected the hospital. The meetings we are referring to are the pre-incorporation meeting and the first formal board meeting. Both occurred in Beverly Hills on December 20, 1976.

A reading of the text of the pre-incorporation agreement gives the impression that no distinction existed between the business of the hospital and the affairs of the corporation. In one section of the agreement labeled "Establishment, Management and Conduct of Corporation's Business", the shareholders discussed in detail the hospital's not yet executed contracts and financing arrangements. The section discusses with unerring accuracy the terms of the ancillary arrangments, the $210,000 loan to the hospital, the real property and equipment leases and the contract for management services. Because of the significance of the pre-incorporation agreement, we are reproducing the major sections of the text that deal with the hospital's contracts and financing arrangements. For clarity, we are including paragraphs that bear on all of the major contracts. The full text of the pre-incorporation agreement is presented in Appendix A.

6. Establishment, Management and Conduct of Corporation's Business. The Stockholders agree to adopt and implement the following procedures and methods with respect to the establishment, management and conduct of the Corporation's business:

6.1 The Corporation shall enter into an ancillary medical services agreement with Perris Valley Medical Center, a California Nonprofit Corporation anticipated to be doing business as Valley Community Hospital, 2224 North Ruby Drive, Perris, California 92370, ("Hospital" herein), consistent with Exhibits "B", "C" and "D" hereto, and pursuant to the terms of which the Corporation shall provide the hospital with such ancillary services, including pharmacy, laboratory, respiratory therapy and cardiopulmonary laboratory, physical therapy, and similar services, and shall provide for the rendering of radiological services. As an integral part of said agreement, the Corporation agrees to loan to said Hospital the sum of Two Hundred Ten Thousand Dollars ($210,000), and shall receive therefor the Hospital's promissory note made payable to the Corporation.

... Said note as well as all fees receivable from the Hospital for the ancillary services rendered by the Corporation shall be secured by a senior security interest in the accounts receivables of the Hospital and by a collateral assignment of its leasehold interest in the real and personal property leased by the Hospital in the conducting of its business. Said contract shall further require the Hospital to name the corporation as an additional insured under the hospital's malpractice insurance coverage.

6.2 The parties hereto acknowledge and agree that the Hospital anticipates entering into a lease pertaining to the real property, wherein Perris Valley Community Hospital, Ltd., a California limited partnership is Lessor, which lease shall be for a term of five (5) years, commencing January 1, 1977, with an option on the part of the Lessor to extend for three (3) additional terms of five (5) years each, and shall provide for rent in the amount of Six Thousand Dollars ($6,000), per month, ...

... Further, it is anticipated that the Hospital will enter into an equipment lease with Tatkin Investment Company, a California corporation, pertaining to the equipment, machinery, furniture, fixtures and other personal property located at the Hospital, which equipment lease shall be for a term of seven (7) years, and shall provide for rental payments in the amount of Five Thousand Dollars ($5,000), per month, commencing January 1, 1977. Said equipment lease shall be net-net-net as well, with the Lessee thereof assuming all expenses pertaining to said equipment. Finally, said Hospital shall have been granted an option by Tatkin Investment Company, the owner of the Perris Valley Medical Building located adjacent to the Hospital, to lease said medical building for a term of five (5) years, commencing March 1, 1977, with an option on the part of Lessor to extend for three (3) additional terms of five (5) years each, at a monthly rental of Three Thousand Two Hundred Dollars ($3,200), net-net-net. ...

> 6.3 It is understood that the Hospital will retain the services of Medical Environments, Inc., a California corporation, to act as management and consultants to the Hospital, in the form appended hereto as Exhibit "A" and incorporated herein. The parties hereto expressly acknowledge that an integral part of the Corporation's agreement to loan the $210,000 to Hospital is dependent upon the services of its President, Mr. Howard S. Kaatz are essential to the successful operation of the Hospital, and hence the repayment by the Hospital of the loan to the Corporation, as aforesaid, agree that this Corporation shall obtain and maintain a policy of term life insurance on the life of Howard S. Kaatz, in an amount not less than the remaining outstanding balance of the loan made by the Corporation to the Hospital.

We should emphasize that the pre-incorporation meeting was held on December 20, 1976. This was a full seven days before the hospital held its first formal board meeting and authorized the execution of the contracts and financing arrangements.

Also on December 20th, the board of Perris Valley Scientific, Inc. held its first formal meeting. The directors authorized the corporation to enter the master ancillary contract and to execute the subcontracts with the shareholders who were providers of ancillary services. Copies of all of the agreements had already been prepared and were attached as exhibits to the minutes. The directors also authorized the loan of $210,000 to the hospital and specified the form of the accompanying security agreement.

- The $210,000 Loan to the Hospital Was Executed with a Restrictive Security Agreement

Two factors about the loan made to the hospital point to interlocking relationships. First, the corporation loaned its entire capitalization of $210,000 to another entity who would become the corporation's sole customer and received an exclusive contract to service the customer for up to 30 years. The chain of events leads us to believe Perris Valley Scientific, Inc. was set up for no other reason than to do business with Community Hospital of the Valleys.

The second factor concerning the loan was the security agreement filed to protect the interests of Perris Valley Scientific, Inc. The agreement was executed on December 29, 1976. Stephen Miller and Ludlow Creary signed for the hospital and Robert Boatwright and Robert Smaeff signed for the corporation. As in the case of the master ancillary contract, shareholders of Perris Valley Scientific, Inc. controlled both sides of the transaction.

The most significant aspect of the security agreement were the terms that effectively transmitted control of the hospital's major decisions to Perris Valley Scientific, Inc. For example, the hospital had to obtain the corporation's written permission before it could change its business structure or corporate structure. The hospital also needed permission to alter its financial structure or business operations if the alterations would impair the interests of Perris Valley Scientific, Inc. as a creditor. Because of the importance of this document, we are reproducing the section of the security agreement that enumerates the restrictions. The complete document is in Appendix B.

> ... B. Debtor represents and warrants and covenants with Secured Party that Debtor will not, without Secured Party's prior written consent: (1) grant a security interest in or permit a lien claim or encumbrance upon any of the collateral to any person, association, firm, corporation, entity, or governmental agency or instrumentality; (2) permit any levy, attachment or restraint to be made effecting any of the Debtor's assets; (3) permit any judicial officer or assignee to be appointed or to take possession of any or all of Debtor's assets; (4) other than in the ordinary course of Debtor's business, to sell, lease, or otherwise dispose of, move, or transfer, whether by sale or otherwise, any of Debtor's assets; (5) change its name, business structure, corporate entity or structure; add any new fictitious name; liquidate, merge or consolidate with or into any other business organization; (6) move or relocate any collateral; (7) acquire any other business organization; (8) enter into any transaction not in the usual course of Debtor's business; ...
>
> ... (11) make any change in borrower's financial structure or in any of its business objectives, purpose or operations, which would adversely affect the ability of Debtor to repay Debtor's obligations to Secured Party; (12) incur any debts outside the ordinary course of Debtor's business except renewals or extentions of existing debts and interest thereon; (13) make any advance or loan except in the ordinary course of business as presently conducted; (14) pay total compensation, including salaries, withdrawals, fees, bonuses, commissions, drawing accounts, and other payments whether directly or indirectly, in money or otherwise, during any fiscal year, to

> all of Debtor's executives, officers, and directors in an unreasonable amount, and in no event in an aggregate amount in excess of 115 percent of those paid in the prior fiscal year; (15) make any planned or fixed capital expenditure, or any commitment therefor, or purchase or lease any real or personal property replacement equipment subject to a purchase money security interest, trust deed or lease in any one fiscal year in excess of its annual allocation to depreciation reserves. ...

Now that we have presented information showing Perris Valley Scientific, Inc. had the opportunity to exercise control, the question is whether control was in fact exercised. This question is examined by reviewing the master ancillary contract.

EXERCISE OF CONTROL

A review of the execution and terms of the master ancillary contract shows that Perris Valley Scientific, Inc. did exercise control over Community Hospital of the Valleys. The particular factors that support this finding are that:

- No evidence exists that the hospital used a competitive bid process to select the ancillary contractor.
- The terms of the master ancillary contract obligated the hospital for 30 years to Perris Valley Scientific, Inc.
- Perris Valley Scientific, Inc. charged percentages that were above market rates.
- A two-tier contracting structure compensated Perris Valley Scientific, Inc. as a conduit that provided no services.

No Evidence Exists of a Competitive Process

Perris Valley Scientific, Inc. did not compete against other providers of ancillary services to secure its contract. Our review of the hospital's files did not develop any evidence that an attempt was made to identify other providers of ancillary services or to solicit competitive bids..

The matter of how Perris Valley Scientific, Inc. became the ancillary contractor was raised by the Internal Revenue Service as part of the process of examining the hospital's filing as a tax exempt organization. The Service in a letter dated March 1, 1978, asked if the hospital considered contracting with anyone other than Perris Valley Scientific, Inc. Stephen Miller prepared the hospital's response in a letter dated May 11, 1978, and flatly stated that no other contractor was considered. Miller, in an apparent attempt to explain the circumstances, stated that Perris Valley Scientific, Inc. was formed for the express purpose of re-opening the hospital as a not-for-profit entity. This reasoning was presented in light of the series of bankruptcies that had plagued the hospital. The full texts of the letter from the Internal Revenue Service and Miller's response are presented in Appendix C.

The 30 Year Length of the Contract

The master ancillary contract was written for an initial term of 15 years with an option for a second 15 year term. The option could be exercised only by Perris Valley Scientific, Inc. As a result of the extraordinary length of the committments, the hospital was potentially locked in to the year 2007.

The length of the contract raises the question as to whether a 30 year obligation could result from negotiations between parties dealing at arms length. It seems highly imprudent for a hospital to commit itself for 30 years to a corporation with no track record of providing ancillary services, no trained staff and no equipment.

Given these circumstances, it was obvious that subcontractors would have to provide the services through contractual arrangements. The master ancillary contract addressed this problem by granting Perris Valley Scientific, Inc. the right to subcontract work and sole discretion to select the individual subcontractor. The master ancillary contract also stated the hospital could not exercise control over the methods by which Perris Valley Scientific, Inc. and its subcontractors performed the services with the exception professional standards had to be observed.

In light of the length of the contract and the strict control granted to Perris Valley Scientific, Inc., we searched the contract for terms that might show concessions on the part of the corporation. The only term that might be construed in this fashion was a clause that discussed the fees that could be charged for ancillary services. Although the hospital was responsible for preparing and collecting patient billings, the actual fees for specific services were dictated by Perris Valley Scientific, Inc. The contract did state the corporation could not set fees inconsistent with those charged by other hospitals in the vicinity.

The contract was silent in terms of putting any constraints or limitations on the percentages charged the hospital. The percentages were fixed for each ancillary service and were in no way tied to prevailing market conditions or fees. In a later section, we show that the percentages were somewhat higher than what could have been secured.

Perris Valley Scientific, Inc. Charged Percentages Above Market

A crucial issue was the relative fairness of the percentages charged the hospital for the ancillary services. Since the hospital did not seek competitive bids prior to awarding the master ancillary contract, we have no record of what other contractors might have offered.

However, we do have data from bids solicited by the hospital in 1980.[2] By comparing the percentages bid in 1980 with those charged by Perris Valley Scientific, Inc., we believe that we can generalize as to the fairness of the contract percentages. The only limitation with the data is that the hospital did not secure bids for physical therapy or radiology, but bids were obtained for the other ancillary services.

2/ The bid data were solicited in 1980 under the direction of the hospital's new management consultant, Ken Hahn. Hahn was attempting to either renegotiate the master ancillary contract to reduce the percentages charged by Perris Valley Scientific, Inc. or to terminate the agreement and select new providers based on competitive bids. As part of this latter process, Hahn directed a solicitation of bids from other suppliers.

An analysis of the bid data showed the percentages charged by Perris Valley Scientific, Inc. were in all cases, except one, higher than the percentages secured by bid. And in the one exception, the bid percentage was equal to the contract percentage.

In some cases, the bid percentages were dramatically lower. For example, one supplier quoted rates that were two-thirds of those charged by Perris Valley Scientific, Inc. The supplier, who was willing to provide all of the basic ancillary services, quoted a blanket 40 percent rate. This compared with the percentages of Perris Valley Scientific, Inc. which ranged from 60 to 85 percent.

The complete record of the bids received and the comparisons with the contract percentages of Perris Valley Scientific, Inc. are presented in Table 7.

The Two-Tier Contracting Structure Inflated Costs

A two-tier contracting structure was established by virtue of Perris Valley Scientific, Inc. subcontracting all of the ancillary services. As a result of this relationship, the hospital paid for a level of overhead that was a contractual conduit. Perris Valley Scientific, Inc. provided no ancillary services itself and our research has not detected any evidence that the corporation was expending resources to manage or coordinate the subcontractors. It should be noted that we did not review Perris Valley Scientific, Inc.'s records and did not discuss it's operations with corporate officers.

The bottom line question is whether the hospital could have bypassed the two-tier contracting structure and contracted directly with providers of ancillary services. Such an arrangement would have avoided the extra costs of Perris Valley Scientific, Inc.'s overhead which was 10 percent of ancillary charges. In theory, the hospital could have bypassed Perris Valley Scientific, Inc., but the obligation of the 30 year contract eliminated this option until the year 2007. Table 8 depicts the two tiers of contractors and their percentage arrangements with Community Hospital of the Valleys.

In summary the contractors obviously had the opportunity to exercise control over the hospital's affairs and it appears equally obvious that such control was exercised in establishing the contractual structure and billing percentages established for Perris Valley Scientific, Inc.

Table 7

Ancillary Bid Data Secured by Community Hospital of the Valleys in 1980

Ancillary Service[a]	Perris Valley Scientific[e] Percentage	Bidder	Bid Percentage[d]
Pharmacy	60%	1	40%
		2	40%
Respiratory[b] Pulmonary Electrocardiology	65%	3	40%
		4	65%
		5	45%+
		2	40%
Clinical Lab	65%	6	60%
		7	50%
		2	40%
Nuclear Medicine[c]	85%	8	60% & 50%

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[a] The hospital did not request bids for radiology and was unable to secure bids for physical therapy.

[b] Bidder 5 submitted a graduated fee calling for 60% for the first $10,000 and 50% for the next $5,000 and 45% for the balance.

[c] Bidder 8 submitted a fee of 60% for ultrasound procedures and 50% for nuclear medicine procedures.

[d] All bids are quoted as a percentage of gross billings except for the 60% of Bidder 6 which is quoted net of contractual allowances.

[e] Includes the 10% surcharge of Perris Valley Scientific.

Table 8

Percentage Arrangements Between the Hospital, Perris Valley Scientific and the Subcontractors

Service	Hospital Tier		Perris Valley Scientific Tier		Subcontracting Tier
clinical lab		----65%----		----55%----	Moye - Boatwright Inc.
a) nuclear medicine		----84%----		----74%----	Universal Nuclear Inc.
respiratory therapy pulmonary lab electrocardiology		----65%----		----55%----	Glen - Tec Respiratory Service
pharmacy		----60%----		----50%----	Perris Hospital Pharmacy Inc.
b) radiology		----35%----		----24%----	Herbert Ulick M.D. Inc.
physical therapy		----65%----		----55%----	National Therapy Associates Inc.

a) The master ancillary contracted called for a percentage of 60 percent, however, the hospital was charged and paid 84 percent until June of 1978 when the percent was raised to 85 percent. No contract modification was executed, but we believe the additional 24 and 25 percent covered the costs of radiologists who interpreted the nuclear medicine tests. The 74 percent arrangement to Universal Nuclear was presumed and has not been confirmed.

b) The original radiology contract called for 24 percent to be paid to Dr. Ulick, however we believe that subsequent contractors were paid 25 percent.

CHAPTER V

MEDICAL ENVIRONMENTS EXERCISED BOTH DIRECT AND INDIRECT CONTROL OVER THE HOSPITAL

This chapter details the relationships between Community Hospital of the Valleys and Howard Kaatz's management firm, Medical Environments, Inc. The material presented establishes that Medical Environments, Inc. was an organization related to Community Hospital of the Valleys. The related organization principle is defined in Chapter IV. The effect of the principle is that allowable costs of the hospital are limited to the actual costs of the related organization. Organizations are defined to be related if common ownership or control exists.

Medical Environment, Inc. was incorporated on December 21, 1976 in California as a for-profit entity. Howard Kaatz was the chief executive officer. He and his wife were the corporation's only stockholders.

Howard Kaatz was a member of the hospital's board when approval was given to contract with Medical Environment, Inc. The contract was approved at the hospital's first board meeting held on December 27, 1976. The minutes of the board meeting show intent and committment of the board to contract with Medical Environments, Inc. The language of the minutes demonstrated the firmness of the committment and is presented below. The full text of the minutes is in Appendix D.

> ... RESOLVED, FURTHER, that it is deemed to be in the best interest of this corporation to retain the services of Medical Environments, Inc., a California corporation, to act as Administrator of the Community Hospital of the Valleys, and accordingly, the officers of this corporation be, and they hereby are, authorized and directed to enter into a management and consulting agreement with Medical Environments, Inc., substantially in the form as that appended hereto as Exhibit "B". ...

When the committment was made to Medical Environments, Inc., the hospital's governing board was composed of Stephen Miller, Howard Kaatz, Ludlow Creary and Linares Johnson.

In connection with the related organization principle, Federal Regulations define control to exist where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. By being one of the hospital's four directors, Kaatz was clearly in a position to influence the major decisions of the hospital's corporation.

A review of the execution and terms of the Medical Environments, Inc.'s contract provided evidence that control was exercised over the hospital's board in obtaining and carrying out the contract.

One indication of control was the fact that the hospital's board did not secure competitive bids from any of the other firms in southern California that provide management services on a contractual basis.

When confronted with the issue in previous Medicare and Medi-Cal audits, the hospital took the position that Medical Environments, Inc. was given the contract because no other firm was willing to undertake the management of the hospital. There are at least three mitigating circumstances which render this position ineffectual:

> First, evidence of the intentions of the hospital are stated in the letter that Stephen Miller wrote to the Internal Revenue Service concerning questions about the hospital's filing as a not-for-profit organization. Miller stated that no other contractor besides Medical Environments, Inc. was considered. The complete text of the letter is in Appendix C.
>
> Second, the Perris Valley Scientific, Inc. pre-incorporation agreement specified that the hospital was to retain the services of Howard Kaatz's firm, Medical Environments, Inc. to provide management services. As approved by its shareholders and the hospital, Perris Valley Scientific, Inc. agreed to loan the hospital $210,000 contingent upon the use of Howard Kaatz's services. Under these circumstances, it is doubtful that the hospital had any intentions of making a genuine effort to solicit proposals.

Third, is the issue of whether the hospital could have secured proposals from other contractors if a serious attempt had been undertaken. Some indication of the probable response can be gleaned from an analysis of the hospital's successful attempt in 1980 to secure proposals from contractors to replace Howard Kaatz. A review of the hospital's minutes showed at least five contractors attended the hospital's board meeting and made formal proposals.

In view of these circumstances, it is evident that competitive bidding procedures were not pursued.

Even if it was accepted that, at the time of the agreement, Medical Environments, Inc. was the only willing contractor, the unusual contract provisions still are not explained. The contract was for a 30-year period with 10-year options that could be elected only by the contractor. The only control retained by the hospital over contract duration was a contract clause providing for termination if either party failed to perform a material covenant or obligation. The extraordinary length of the agreement can be demonstrated by making comparisons with the average length of other management agreements. In a study performed by a private consulting firm of 78 hospitals operating under management contracts, the average contract term was 1.7 years for not-for-profit hospitals and 2.3 years for proprietary hospitals.1/

The fact that Medical Environments, Inc. held no other contracts and was incorporated just six days prior to receiving the contract from the hospital makes the contract duration even more unusual. Under these circumstances, a prudent hospital might have executed a two or three year agreement with the option for both parties to elect an additional term.

Considering the above contract provisions and Howard Kaatz's membership on the hospital's board, we can only conclude that significant influence was exercised over the hospital in negotiating the contract for its management services and that Medical Environments, Inc. and Community Hospital of the Valleys were related organizations.

1/The study was performed by the firm of Lewin and Associates and was printed in the June 16, 1981 issue of Hospitals on pages 59-62.

BEST DOCUMENT AVAILABLE

CHAPTER VI

IMPROPER ACTIONS BY THE MAJOR CONTRACTORS AND THE HOSPITAL

This chapter deals with specific improper actions taken by Medical Environments, Inc. in its management of Community Hospital of the Valleys; Perris Valley Scientific, Inc. in attempting to maintain its control over the hospital's administration; and the hospital in changing the minutes of the Board of Directors meetings. These improprieties were caused and/or perpetuated by the fact that the major contractors controlled the hospital's board. These acts provide evidence that structures such as Community Hospital of the Valleys result not only in inflated Medicare and Medi-Cal costs but may also lead to other types of improprieties.

HOWARD KAATZ AND MEDICAL ENVIRONMENTS, INC.

In focusing on Howard Kaatz and Medical Environments, Inc., some inefficiencies in the management of the hospitals day-to-day affairs are readily discernable.

It appears that Medical Environments, Inc. did little or nothing to control the cost of the hospital's malpractice insurance. During the years Medical Environments, Inc. managed the facility, the malpractice insurance policy costs were about $92,000 per year. By shopping around, Ken Hahn, the management consultant who replaced Howard Kaatz, was able to purchase comparable coverage for about $20,000 for the first year of his tenure and about $61,000 for what would have been the second year.

Questionable management of the hospital's finances is also evident in the method used by Howard Kaatz to transport checks from the Medicare intermediary. The Medicare checks were transported from the Medicare intermediary in Woodland Hills to Perris by an air messenger service, the Royal Burbank Air Force. Howard Kaatz served as a director and chief financial officer of this air messenger service. The cost of these services was between $5,000 and $6,000 per year. However, the service provided no real benefits over regular mail service.

The checks were delivered so late in the afternoon that deposits were not made until the next day. This delay wiped out the benefits of moving the checks by air. When Medical Environments, Inc. was replaced, the messenger service was stopped and the hospital relied on regular mail delivery which provided satisfactory service.

The Royal Burbank Air Force was also used to transport patient billings to Medicare on the return flights from the hospital. At least this was the approach until tests run by hospital staff showed registered mail moved the billings just as fast or faster. Subsequently, the hospital ceased transporting the billings by air, but continued using the Air Force to move checks from Woodland Hills.

The costs incurred for the services of the Royal Burbank Air Force totaled approximately $17,000 for 1977, 1978 and 1979.

The final evidence of mismanagement led to the replacement of Howard Kaatz and Medical Environments, Inc.

Without the authorization or knowledge of Community Hospital of the Valleys' Board of Directors, Howard Kaatz loaned $88,500 of the hospital's money to Lincoln Hospital, another facility under contract to Medical Environments, Inc. The loans were made in a series of six installments over a four month period and were executed without any written agreement with Lincoln Hospital. The loans were made at a time when Community Hospital of the Valleys was experiencing serious cash flow problems and could not meet its obligations to its suppliers or physicians. This was such a serious breach of the contract that it became grounds for the hospital board to terminate the Medical Environments, Inc. contract in February of 1980.

PERRIS VALLEY SCIENTIFIC, INC.

In April of 1980, Ken Hahn replaced Medical Environments, Inc. as management consultant for Community Hospital of the Valleys. Perris Valley Scientific, Inc.'s struggle to gain control over the hospital's management soon surfaced. This led to improper acts on the part of Perris Valley Scientific, Inc. The information in this section was obtained through interviews with Kenneth Hahn and is based on his signed affidavit.

Shortly after assuming the management responsibilities, Hahn concluded that Community Hospital of the Valleys' major financial problem was its master ancillary contract with Perris Valley Scientific, Inc. He came to this conclusion based on two major points. First, Medicare and Medi-Cal had sharply reduced the hospital's cash flow by cutting back the interim reimbursement rates because of the related organization problems. Unless action was taken to eliminate the problems, the hospital would continue to be paid at interim rates 20-30 percent below the hospital's billings.

The cutbacks were devastating to the hospital's cash position since the reductions could not be passed through to Perris Valley Scientific, Inc. The master ancillary contract was constructed to insulate the contractors from Medicare and Medi-Cal cutbacks. No matter what happened to the hospital's reimbursement, the contractors could charge the same percentages for their services. Since the cutbacks were not shared and the hospital could not pay its full obligation, the hospital incurred an enormous debt to Perris Valley Scientific, Inc. At the time of the bankruptcy, the debt topped $1,800,000 which was in addition to the $210,000 loaned to the hospital and the accumulated interest charges.

Secondly, the percentages charged by Perris Valley Scientific, Inc. were excessive in comparison with market rates. This was later demonstrated by the bids submitted by competing firms. With one exception, the bids proposed lower percentages than those charged by Perris Valley Scientific, Inc. Because of these problems Ken Hahn initiated negotiations with Perris Valley Scientific, Inc. to terminate or modify the contract.

The negotiations were extremely complicated because of the linkages between the hospital and Perris Valley Scientific, Inc. In particular, the negotiations focused on the debts owed to the corporation, the future role of Stephen Miller, the composition of the hospital board, and the manner in which the hospital would contract for ancillary services. Although different positions and counter-positions were considered, no lasting agreements were reached.

A consensus was reached that Perris Valley Scientific, Inc. could not remain as the hospital's ancillary services contractor in light of the reimbursement problems with Medicare and Medi-Cal. Both sides agreed in principle that the master ancillary contract had to be terminated. However, the subcontractors wanted to retain their rights to provide the ancillary services by contracting directly with the hospital and bypassing Perris Valley Scientific, Inc. By removing the corporation, the shareholders believed they could avoid the related organization problem.

The negotiations reached the point where Perris Valley Scientific, Inc. prepared a draft document terminating the master ancillary contract. The document was transmitted to Hahn and the hospital in November of 1980. The main points appeared to be the composition of the hospital board and the repayment of the outstanding debt. Perris Valley Scientific, Inc. wanted to control several seats on the hospital's governing board and to force the hospital into a near-term plan to repay the debt. Hahn and most of the governing board and medical staff found the proposed settlement terms unacceptable. Hahn and the others representing the hospital were not willing to provide the contractors with so much control or to repay the debt over the short time specified in the proposed agreement.

About the same time that Ken Hahn received the proposed agreement to terminate the master ancillary contact, he also received another document from Stephen Miller. This document was in affect a partnership offer and offered Hahn, for no cash, a 5 percent limited interest in the profits and losses of Perris Valley Scientific, Ltd. and the option to purchase an additional 5 percent for $50,000. In return, Hahn was to be obligated to continue providing consulting services to the hospital and Perris Valley Scientific was to take actions to ensure Hahn's status as a contractor.

The document identified Perris Valley Scientific, Ltd. as a limited partnership that held the option to acquire the hospital real property from Allen Tatkin. The general partner was the corporation, Perris Valley Scientific, Inc.

The document also discussed the potential problems that Hahn's partnership would cause with Medicare and Medi-Cal. By virtue of being owner in Perris Valley Scientific, Ltd. and a hospital contractor, Hahn could be declared a related organization. Since this would lead to a possible disallowance of the contract fees and further deplete the hospital's assets, no evidence of a partnership agreement other than the proposal letter was to be prepared.

The partnership offer is included as Exhibit I to this report. This document is in the form of a five page typed letter addressed to Mr. Hahn and is not signed or dated. It was obtained from Mr. Hahn as a part of his sworn affidavit.

COMMUNITY HOSPITAL OF THE VALLEYS

During the audit of the hospital two sets of minutes for the hospital's Board of Directors meetings were observed. One set was obtained from the hospital's files and the other set from the Health Audits Bureau cost reimbursement audit files. The principle difference in the two sets of minutes was the composition of the Board of Directors of the hospital. Table 7 depicts the composition of the board as presented in each set of minutes as the major transactions of the hospital took place. Under either set of minutes the hospital and its contractors would be related entities but the set found in the hospital's files shows a stronger relationship.

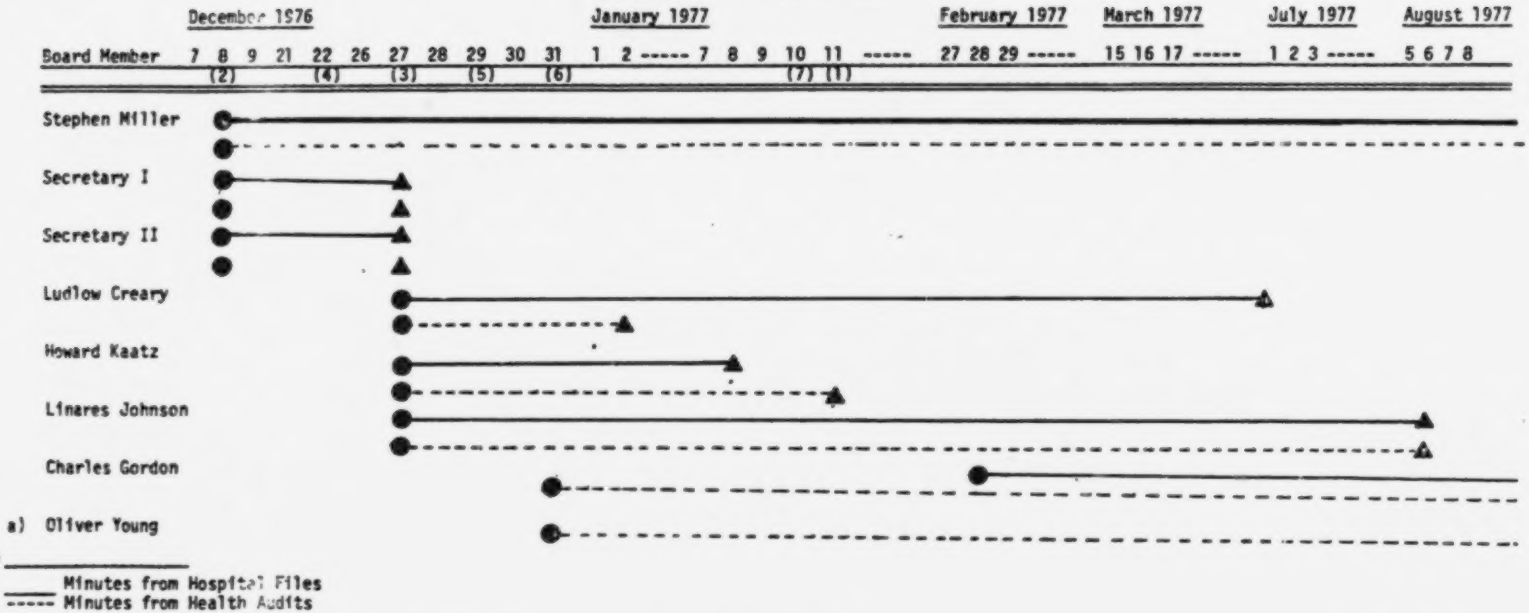
Comparison of the composition of Board of Directors in relation to the major events in the early days of the hospital indicates that the minutes obtained from the hospital's files show a much stronger basis for application of the related entities regulation to the hospital and the ancillary services and management consultant contractors than the minutes obtained from Health Audits.

Since there are two sets of minutes covering the same period, one set is false. If the set presented to Health Audits is false, the hospital has been involved in an inappropriate act that appears to be an attempt to mislead the Health Audits Bureau auditors by manipulation of the hospital's board membership and thus prevent the related entity charges raised by those auditors and again in this report.

The events discussed in this chapter are evidence that the major contractors' control over Community Hospital of the Valleys contributed to improprieties in the hospital's management and financial affairs. It was demonstrated in an earlier chapter that Howard Kaatz exercised control over the hospital board in negotiating such an advantageous contract for Medical Environments, Inc. In regards to the ancillary services contract, it is obvious that Perris Valley Scientific, Inc. benefited from its control over Community Hospital of the Valleys and had no wish to relinquish that control. The partnership offer was an obvious ploy by Perris Valley Scientific, Inc. to gain control over Hahn, thereby securing its position of control over the hospital. It is equally obvious, upon reading the partnership offer, that Perris Valley Scientific, Inc. was fully aware of the related organization issue. It is apparent that these improprieties are a direct result of the major contractor's struggle to maintain control over the hospital.

TABLE 9

Comparison of the Board's Composition in the Minutes From Hospital Files and the Minutes From Health Audits Files During Major Events



a) Oliver Young was not mentioned in the hospital file minutes until December 8, 1977.

(1) PVS Contract Approved
(2) Hospital Incorporated
(3) First Board Meeting
PVS Contract Authorized
Medical Environments Contract Authorized
(4) Land Building and Equipment Leases
(5) $210,000 Promisory Note and Security Agreement Executed
(6) Acquired Operating License
(7) Hospital Opened

CHAPTER VII

CONCLUSION AND RECOMMENDATIONS

CONCLUSION

This report is a summary of the review of one California hospital. Although this hospital certainly does not exemplify all California hospitals it does give an indication of the problems that may exist within the State and the manner in which the Medi-Cal program may be abused by hospitals.

This report reviewed the incorporation of the hospital and the establishment of the hospital's major service providers. Based on this review we must conclude that the major contractors of Community Hospital of the Valleys were a family of common interests who exercised control over the hospital when their contracts were negotiated. By virtue of this control the contractors were related organizations as defined by Medicare and Medi-Cal cost reimbursement regulations.

This relatedness finding is the basis for our first two recommendations which relate specifically to Community Hospital of the Valleys. Our other recommendations stem from the programmatic abuse observed in the review of Community Hospital of the Valleys.

RECOMMENDATIONS

Recommendation 1

Our review leads us to believe that the hospital's major contractors engaged in improper acts. We recommend that the Department of Health Services request that the State Attorney General review the report and the documentation gathered by the State Controller's Office to determine if State laws have been violated. This Office will provide any information we have including the audit workpaper files, and any assistance necessary to make such a determination.

Recommendation 2

We recommend that the Department of Health Services continue to actively pursue the recovery of the currently outstanding audit adjustments. The hospital claimed for reimbursement approximately $5,789,900 in costs due to transactions with the management and ancillary services contractors during 1977 and 1980. This figure represents both Medicare and Medi-Cal costs, but does not include the last five months of the hospital's operation. The evidence presented in this report demonstrated that the costs claimed for these services should be reduced to the costs of the contracting organizations. By virtue of interim adjustments, based on estimates, the Medicare and Medi-Cal auditors have recovered a portion of the monies due the programs. However, the full amount can only be determined by obtaining and auditing the contractors records.

It should be noted that previous requests of the Medicare and Medi-Cal auditors to be allowed to review the records have been denied. Obviously, efforts to obtain the records must be continued. There is also a question as to whether the audit adjustments, once determined, may be recouped. Since the hospital is in bankruptcy and Perris Valley Scientific, Inc. is a secured creditor it will be difficult for the Medicare and Medi-Cal programs to recover monies from the bankruptcy proceeding. However, the programs may be able to recoup some of the bankruptcy proceeds if the security agreement can be invalidated because of the contractors relationship to the hospital. The only other alternative is to pursue the contractors directly for the audit adjustments.

The following recommendations relate to the overall Medi-Cal program. While it is obvious that the benefits of such social programs as Medi-Cal outweigh the inherent drawbacks, including the possibility of abuse and manipulation of the program by vendors and recipients, it is also obvious that the State of California and the Department of Health Services must strengthen their efforts to discover and prevent fraud and abuse within the program. In line with this need, we make the following recommendations.

Recommendation 3

The Department of Health Services should develop an ongoing review program which will utilize the cost information developed by the Health Facilities Commission to identify hospitals with potentially abusive corporate structures. The hospitals identified with such structures should then be subjected to an audit to determine if any program abuses exist. The existence of such a review program would serve not only as a means of identifying hospitals currently attempting to manipulate the Medi-Cal program but also as a deterrent to future abuses.

Recommendation 4

The Department of Health Services should seek the establishment of penalties for hospitals which fail to disclose major contracts with related entities. Currently hospitals are required to disclose such contracts as a part of their reporting to the Health Facilities Commission. The report forms contain a penalty of perjury citation for the administrator signing the report but there are no penalties established or enforced for failure to supply this information. Currently when such situations are discovered by Medicare or Medi-Cal audits the hospitals reimbursements are reduced to the costs of the providers but no penalties are assessed. We believe that institution of penalties or fines will reduce the incidence of such reporting failures.

Recommendation 5

We recommend that the Department of Health Services pursue the establishment of regulations which would provide for fiscal recoveries directly from contractors if they can be shown to be related entities and the hospital is unable to reimburse the State for the amounts in question. We recognize that the establishment of such regulations would require legislative action. We believe that such regulations would strengthen the fiscal controls over the Medi-Cal program.

Recommendation 6

Currently, there are no Federal or State regulations which require hospitals to use competitive bid procedures in selecting their major services providers. We recommend that the Department of Health Services seek the establishment of regulations which require hospitals to utilize competitive bid procedures to select major services contractors. We believe the establishment of such a requirement would not only reduce the incidence of related entity transactions but also help to reduce health care costs in general.

Appendix A

PRE-INCORPORATION AGREEMENT

THIS AGREEMENT is made and entered into as of December 20, 1976, at Beverly Hills, California, by and between ROBERT BOATWRIGHT, SALVADOR MOYE, ROBERT SHMAEFF, GLEN E. CONLEY, STEPHEN K. MILLER, LUDLOW B. CREARY, M.D., and THEODORE WOLF, hereinafter collectively referred to as "Stockholders", and individually referred to as "Stockholder", or by their respective names. This Agreement is made with respect to the following facts and circumstances:

A. It is proposed to form a new corporation under the laws of the State of California under the terms and conditions hereinafter set forth, to engage in the business of rendering ancillary services to hospitals, clinics, first-aid stations and similar medical facilities, including, but not by way of limitation, the operation of a pharmacy and laboratory, the rendering of respiratory therapy and cardiopulmonary laboratory and physical therapy services, and the providing for the rendering of radiological services; and

B. It is proposed that said corporation be authorized to issue one clads of shares of its capital stock consisting of One Hundred Thousand (100,000) shares having a par value of Ten Dollars ($10.00) each; and

C. It is proposed that the corporation initially engage the services of ROBERT BOATWRIGHT and SALVADOR MOYE, or their entity, to provide the laboratory services, ROBERT SHMAEFF, or his entity, to provide the pharmacy services, and GLEN E. CONLEY or his entity, to provide respiratory therapy and cardiopulmonary laboratory services to be conducted by the corporation; and

D. It is desired that Messrs. BOATWRIGHT, NOYE, SIMAEFF and CONLEY grant to the corporation the option to acquire all of their shares of the corporation should they, or their entities, cease providing the services to be rendered by them on behalf of the corporation; and

E. It is deemed advisable that no other person, including the respective spouses of the Stockholders be permitted to own any stock in said corporation except as pursuant to the provisions of this Agreement; and

F. It is desired to protect said Corporation and the Stockholders upon the death or disablement of any of the Stockholders before the termination of this Agreement.

NOW, THEREFORE, in consideration of the mutual promises and covenants of the parties contained herein, the parties hereby agree as follows:

1. Formation of Corporation. The Stockholders shall cause a new corporation to be formed pursuant to the laws of the State of California, to be known as "PERRIS VALLEY SCIENTIFIC", hereinafter referred to as the "Corporation".

2. Articles of Incorporation. The Corporation shall be organized so as to provide for the following:

2.1 The principal place of business of the Corporation shall be Riverside County, California, provided, however, that the Corporation may maintain such additional facilities as the Board of Directors may hereafter direct.

2.2 The initial number of Directors of the Corporation shall be three (3).

2.3 The Corporation shall be authorized by its Articles of Incorporation to issue one class of shares of stock consisting of One Hundred Thousand (100,000) shares having a par value of Ten Dollars ($10.00) per share, and an aggregate value of One Million Dollars ($1,000,000.00).

2.4 The primary business in which the Corporation shall engage is in the business of rendering ancillary services to hospitals, clinics, first-aid stations and similar medical facilities, including, but not by way of limitation, the operation of a pharmacy and laboratory, the rendering of respiratory therapy and cardiopulmonary laboratory and physical therapy services, and the providing for the rendering of radiological services.

2.5 A quorum of the Board of Directors for the transaction of the Corporation's business shall consist of a majority of the Directors then in office; provided, however, that any act or decision done or made by the unanimous written consent of the Directors, without a meeting, shall be valid and constitute the act or decision of the Board of Directors.

3. Agreement to Subscribe. Each subscriber hereto will purchase, and each of them does hereby subscribe for, the number of shares of stock of the Corporation as shown hereinafter, and agrees that he will pay, in cash or certified check, Ten Dollars ($10.00) per share therefor to the Corporation at such time as the sale of such shares has qualified with the Commissioner of Corporations of the State of California. In this regard, the parties acknowledge that the sale of the securities which are the subject of this Agreement has not been qualified with the Commissioner of Corporations of the State of California and the issuance of such securities or the payment or receipt of any part of the consideration therefor prior to such qualification is unlawful. The rights of all parties to this Agreement are expressly conditioned upon such qualification being obtained. Pending such

qualification, each of the subscribers hereto agrees to deposit with the law firm of Rubin and Miller, a Professional Corporati the full purchase price for the shares subscribed for hereunder, which deposit shall be returned should the shares not be issued within ten (10) days following the execution of this Agreement.

ROBERT BOATWRIGHT		875 shares
SALVADOR MOYE		875 shares
ROBERT SHWAEFF		1,500 shares
GLEN E. CONLEY		750 shares
STEPHEN K. MILLER		625 shares
LUDLOW B. CREARY, M.D.		375 shares
THEODORE WOLF		250 shares
	TOTAL	5,250 shares

4. Agreement to Loan Money to Corporation. Each subscriber hereto agrees to loan to the Corporation the amount of money set forth after his name hereinbelow, and shall receive from the Corporation a promissory note in the principal amount of his loan, bearing interest at the rate of nine per cent (9%) per annum, payable in sixty (60) equal monthly installments, including principal and interest, the first such payment commencing May 1, 1977, and the first day of each month thereafter until paid:

ROBERT BOATWRIGHT		$26,250.00
SALVADOR MOYE		$26,250.00
ROBERT SHWAEFF		$45,000.00
GLEN E. CONLEY		$22,500.00
STEPHEN K. MILLER		$18,750.00
LUDLOW B. CREARY, M.D.		$11,250.00
THEODORE WOLF		$ 7,500.00
	TOTAL	$157,500.00

5. Control. The Stockholders shall vote their stock so as to provide for the following:

5.1 The Directors shall be ROBERT BOATWRIGHT, GLEN E. CONLEY and ROBERT SHWAEFF.

5.2 The officers during the Corporation's first annual period shall be:

President - ROBERT BOATWRIGHT
Vice-President - GLEN E. CONLEY
Secretary - ROBERT SHWAEFF
Treasurer - GLEN E. CONLEY

6. Establishment, Management and Conduct of Corporation's Business. The Stockholders agree to adopt and implement the following procedures and methods with respect to the establishment, management and conduct of the Corporation's business:

6.1 The Corporation shall enter into an ancillary medical services agreement with Perris Valley Medical Center, a California Nonprofit Corporation anticipated to be doing business as Valley Community Hospital, 2224 North Ruby Drive, Perris, California 92370, ("Hospital" herein), consistent with Exhibits "B", "C" and "D" hereto, and pursuant to the terms of which the Corporation shall provide the hospital with such ancillary services, including pharmacy, laboratory, respiratory therapy and cardiopulmonary laboratory, physical therapy, and similar services, and shall provide for the rendering of radiological services. As an integral part of said agreement, the Corporation agrees to loan to said Hospital the sum of Two Hundred Ten Thousand Dollars ($210,000), and shall receive therefor the Hospital's promissory note made payable to the Corporation in the principal amount of sai loan, payable in sixty (60) equal monthly installments of principal and interest computed at the rate of nine per cent (9%) per annum, the first such payment being due on May 1, 1977, and on the first day of each and every month thereafter until said note is paid. Said note as well as all fees receivable from the Hospital for the ancillary services rendered by the Corporation shall be secured by a senior security interest in the accounts receivables of the Hospital and by a collateral assignment of its leasehold interest in the real and personal property leased by the Hospital in the conducting of its business. Said contract shall further require the Hospital to name the corporation as an additional insured under the hospital's malpractice insurance coverage.

6.2 The parties hereto acknowledge and agree that the Hospital anticipates entering into a lease pertaining to the real property, wherein Perris Valley Community Hospital, Ltd., a California limited partnership is Lessor, which lease shall be for a term of five (5) years, commencing January 1, 1977, with an option on the part of the Lessor to extend for three (3) additional terms of five (5) years each, and shall provide for rent in the amount of Six Thousand Dollars ($6,000), per month, payable in advance on the first (1st) day of each and every month during the term thereof. Said lease shall be net-net-net, so that all expenses pertaining thereto, including repairs, insurance and taxes shall be paid by the Lessee thereof in addition to the rent payments made to the Lessor. Further, it is anticipated that the Hospital will enter into an equipment lease with Tatkin Investment Company, a California corporation, pertaining to the equipment, machinery, furniture, fixtures and other personal property located at the Hospital, which equipment lease shall be for a term of seven (7) years, and shall provide for rental payments in the amount of Five Thousand Dollars ($5,000), per month, commencing January 1, 1977. Said equipment lease shall be net-net-net as well, with the Lessee thereof assuming all expenses pertaining to said equipment. Finally, said Hospital shall have been granted an option by Tatkin Investment Company, the owner of the Perris Valley Medical Building located adjacent to the Hospital, to lease said medical building for a term of five (5) years, commencing March 1, 1977, with an option on the part of Lessor to extend for three (3) additional terms of five (5) years each, at a monthly rental of Three Thousand Two Hundred Dollars ($3,200), net-net-net. Included within said option granted by Tatkin Investment Company to the Hospital is the right to possession of said medical building commencing January 1, 1977, through and until February 28, 1977, at no rent, but the Lessee thereof shall assume all obligations pertaining to the maintenance and operation of said medical building.

6.3 It is understood that the Hospital will retain the services of Medical Environments, Inc., a California corporation, to act as management and consultants to the Hospital, in the form appended hereto as Exhibit "A" and incorporated herein. The parties hereto expressly acknowledge that an integral part of the Corporation's agreement to loan the $210,000 to Hospital is dependent upon the services of Medical Environments, Inc., and particularly the services of its President, Mr. Howard S. Kaatz. The Stockholders, believing that the services of Howard S. Kaatz are essential to the successful operation of the Hospital, and hence the repayment by the Hospital of the loan to the Corporation, as aforesaid, agree that this Corporation shall obtain and maintain a policy of term life insurance on the life of Howard S. Kaatz, in an amount not less than the remaining outstanding balance of the loan made by the Corporation to the Hospital.

6.4 As soon as practical after the formation of t Corporation, the Corporation shall enter into agreements with

ROBERT BOATWRIGHT and SALVADOR MOYE, or their entity, pertaining to laboratory services, in the form as that appended hereto as Exhibit "B", with ROBERT SHAEFF, or his entity, pertaining to pharmacy services, in the form as that appended hereto as Exhibit "C", and GLEN E. CONLEY, or his entity, pertaining to respiratory therapy and cardiopulmonary laboratory services, in the form as that appended hereto as Exhibit "D". Said agreements shall provide that the Corporation shall be named as an additional insured in each of said individuals' or entities' malpractice or errors and omission insurance pertaining to the services being rendered for the Corporation pursuant hereto.

6.5 The Corporation shall be authorized to employ such personnel as shall be deemed necessary by the Board of Directors to perform other services for the benefit of the Hospital or for other medical facilities, on such terms and provisions as shall be decided by the Board of Directors. In this regard, it is agreed by the parties hereto that the Corporation shall retain Rubin and Miller, A Professional Corporation, as its attorneys, which attorneys shall be entitled to reasonable fees for services rendered on behalf of the Corporation. Except as is expressly provided in this Agreement, no party to this Agreement shall be entitled to any salary by the Corporation, unless and until the Board of Directors of the Corporation shall unanimously so decide. Notwithstanding the foregoing to the contrary, the Corporation shall reimburse each of its employees, directors, officers and shareholders for all ordinary and necessary reasonable expenses incurred in the conducting of the Corporation's business.

6.6 Except for checks authorized by the Board of Directors of the Corporation, all corporate checks in amounts over One Thousand Dollars ($1,000.00) shall require the signature of at least two (2) officers of the Corporation.

7. Books and Records. The Corporation shall keep a complete and accurate set of books and records relating to all business activities carried on by the Corporation in the conduct of its business. Such books and records shall be kept in accordance with good and generally accepted accounting principles and practices, applied on a consistent basis, and any Stockholder shall have the right at all reasonable times to inspect said books and records at his own expense.

8. Election Under Subchapter S. The Stockholders agree that it would be for the benefit of the Stockholders for the Corporation to elect to be taxed as a small business corporation under the provisions of Subchapter S of the Internal Revenue Code of 1954, as amended, and, accordingly, agree to execute such documents and take such steps, individually and on behalf of the Corporation, as shall be necessary to effectuate said election.

9. Restriction on Transfer of Stock During Lifetime. Notwithstanding any provisions herein to the contrary, the parties hereto agree that no Stockholder shall transfer, assign, hypothecate or in any way alienate any of his shares or any right or interest therein, either voluntarily or by operation of law, except pursuant to the following terms and conditions:

9.1 In the event any Stockholder should desire to dispose of his shares of stock in the Corporation, during his lifetime, he shall first give written notice to the Secretary of the Corporation of his intention to do so setting forth the proposed transferee, the number of shares to be transferred, and the price per share. Within a sixty (60) day period following the receipt of such notice by the Secretary, the Corporation shall have the right and option to purchase any such shares at the price stated in the notice by giving written notice of its election to exercise such option to such Stockholder. The right of the Corporation to exercise such stock is subject to the restrictions governing the right of a corporation to purchase its own stock contained in §1705 of the California Corporations Code and such other pertinent governmental restrictions as are now or may hereafter become effective.

9.2 If all such shares are not purchased by the Corporation within said sixty (60) day period, all such shares shall then be offered at the same purchase price and terms to each of the other Stockholders who shall have the right and option to purchase such portion of the shares offered for sale as the number of shares owned by him at such date shall bear to the total number of shares held by all Stockholders desiring to purchase said shares by giving written notice of his election to exercise such option to such Stockholder; provided, however, that if any of the other Stockholders do not purchase their full proportionate part of the shares, the unaccepted shares may be purchased by the other Stockholders.

9.3 Any shares mentioned in such notice of intention to transfer not so purchased by the Corporation or any other Stockholder may be transferred at any time within six (6) months from the date of such notice, but only upon the terms and conditions specified herein.

10. Mandatory Redemption on Death. Within sixty (60) days after the death of any Stockholder, the Corporation shall purchase, and the estate of the deceased Stockholder shall sell, all of the shares of stock of the Corporation owned by the deceased Stockholder at the price hereinafter provided. If the

Corporation does not at that time have sufficient earned or existing surplus available to permit it lawfully to redeem any or all of said shares, the surviving Stockholders and the legal representative of the deceased Stockholder shall perform such acts, execute such instruments, and vote their shares in such manner as may be necessary to create sufficient reduction surplus to permit said redemption to the extent legally possible. If it is not legally possible to create sufficient surplus to allow the Corporation to purchase such shares, the surviving Stockholders shall purchase and pay for any and all of said decedents shares not to be redeemed by the Corporation, at said price and at the terms hereinafter stated.

10.1 The purchase price of which shares shall be purchased or redeemed shall be a figure which bears the same proportionate relationship to the net book value of the Corporation at the number of shares to be purchased or redeemed bears to the total number of shares outstanding. Net book value shall be determined by the Certified Public Accountant then in charge of the books of the Corporation in accordance with generally accepted accounting principles consistently applied and the following shall be observed:

10.1.a No allowance of any kind shall be made for good will, trade names, or any similar intangible asset.

10.1.b All accounts payable shall be taken at the face amount, less discounts deductible therefrom and all accounts receivable shall be taken at the face amount therefor, less discounts to the customer and a reasonable reserve for bad debts.

10.1.c Inventory, if any, shall be valued at cost or market, whichever is lower.

10.1.d Machinery, fixtures, equipment and any option granted to the shareholders of FERRIS VALLEY SCIENTIFIC to purchase the Hospital property or equipment or otherwise (which option, for purposes of Sections 9, 10 and 11 hereof shall be deemed to be included in the term "shares"), shall be valued at fair market value, as determined by appraisal.

10.1.e All unpaid and accrued taxes shall be taken as liabilities.

Notwithstanding the foregoing, the Stockholders may at any time fix the agreed value of the stock in the Corporation by a Certificate of Agreed Value signed by each Stockholder and filed with the Corporation. If at any time when it becomes necessary to determine the book value of the stock of the Corporation, and a Certificate of Agreed Value is dated less than one (1) year before the date as of which the book value is to be determined, then the agreed value set forth in such Certificate of Agreed Value shall be conclusive as of the date on which the net book value is to be determined. In no event shall a Certificate of Agreed Value be effective unless signed by all the Stockholders nor shall any but the last Certificate of Agreed Value be effective, if at all, for the purpose herein specified.

10.2 The purchase price shall be payable one-half (1/2) in cash upon transfer of the stock and the balance forthwith by delivery of a promissory note containing the provisions and secured in the manner hereinafter prescribed.

10.3 The Corporation may at its option, purchase or cause to be purchased insurance on the life of each Stockholder in an amount equal to the estimated purchase price of shares (as determined in Paragraph 10.1 hereof) of the stock of each Stockholder to assure performance of the Corporation's obligation to purchase and redeem the stock of the deceased party under this Section 10 of this Agreement, and the Corporation shall adjust the amount of the insurance, from time to time, so as to keep the face amount of the policies in reasonable relationship to the net book value; provided, however, that the Corporation shall not be liable for failure of the amount of the insurance to bear such a relationship to the net book value. The Corporation shall pay all premiums on such policies but shall not, without the written consent of all Stockholders, exercise any right of ownership therein (except to collect death benefits therefrom) or modify or impair any of the rights or values of such policies. Upon the termination of this Agreement pursuant to Section 15 hereof, or upon the sale or disposition of all his stock in the Corporation, each Stockholder shall have the right, within thirty (30) days after such termination or disposition to purchase from the Corporation such policy or policies of insurance on his life owned by the Corporation at a price equal to the cash surrender value thereof on the date of termination or disposition. The insured shall have no further rights in any policies not purchased within said thirty (30) day period.

10.4 It is further understood and agreed by the parties to this Agreement that in the event it becomes necessary to determine the net book value of the Corporation for any purpose whatsoever, there shall be included within such determination such adjustments as shall be necessary to reflect the remaining balance of any loan made by the Stockholder whose shares are to be purchased, and further, the remaining balance of said loan shall not be affected by said purchase, it being the intention that the Corporation will continue making the payments to the said Stockholder until the remaining balance of the loan has been paid, either as per the terms of the note pertaining to said loan, or by agreement between the Corporation and said Stockholder.

11. Option to Redeem Shares.

11.1 It is the intention and agreement of the parties hereto that the Corporation shall have the option to redeem all of the shares owned by Messrs. BOATWRIGHT and NOYE should they or their entity cease rendering the laboratory services on behalf of the Corporation if said cessation occurs without any breach on the part of the Corporation of the Agreement attached hereto as Exhibit "B". Likewise, the Corporation shall have the option to purchase the shares of ROBERT SHMAEFF should he or his entity cease rendering the pharmacy services on behalf of the Corporation if said cessation occurs without any breach on the part of the Corporation of the Agreement attached hereto as Exhibit "C". Additionally, the Corporation shall have the option to acquire the shares of GLEN E. CONLEY should he or his entity cease rendering the respiratory therapy and cardiopulmonary laboratory services on behalf of the Corporation if said cessation occurs without any breach on the part of the Corporation of the Agreement attached hereto as Exhibit "D". Finally, should any of the aforesaid entities be sold, assigned or transferred, in whole or in part, by any of the individuals herein named, said act shall further give rise to the option granted herein.

11.2 Should the option to purchase said shares become exercisable, the Corporation shall have a period of thirty (30) days to purchase all, but not less than all, of the Corporation's shares held by such Stockholder or Stockholders by giving written notice of its election to exercise such option to such Stockholder or Stockholders.

11.3 In the event that shares are purchased by the Corporation pursuant to the provisions of this Paragraph, the purchase price for such shares shall be determined in the manner set forth in Paragraph 10.1 of this Agreement.

12. Note and Security For Payment. If any part of the purchase price for shares purchased or redeemed pursuant to Sections 10 or 11 of this Agreement is paid in the form of a note, the note shall provide for payment of principal in not more than twenty-four (24) equal monthly installments, each plus interest on the unpaid balance at the rate of seven per cent (7%) per annum, with the full privilege of prepayment of all or any part of the principal at any time without penalty or bonus. The note shall provide that in the case of any default at the election of the holder, the entire sum of principal and interest shall immediately become due and payable and for the payment by the maker of reasonable attorneys' fees to the holder in the event suit is commenced because of any default.

13. Endorsement on Share Certificate. Each share certificate of Corporation, when issued, shall have endorsed upon its face the following words:

> "Sale, transfer or hypothecation of the shares represented by this certificate is restricted by the provisions of an Agreement dated Dec. 20, 1976, a copy of which may be inspected at the principal office of the Corporation, and all of the provisions of which are incorporated herein."

A copy of this Agreement shall be delivered to the Secretary of Corporation, and shall be shown by him to any person making inquiry concerning it.

14. Inter Vivos Transfers. Shares of the Corporation may not be transferred by inter vivos gift, nor may shares of the Corporation be hypothecated in any way: provided, however, that any Stockholder may declare himself Trustee of all or any of his shares for the benefit of another or others, on the condition that such Stockholder shall remain the Stockholder of record

of such shares, and such shares shall remain subject to all of the terms and conditions of this Agreement.

15. Termination of Agreement. This Agreement shall terminate, except for any continuing duty of the Corporation or any Stockholder or Stockholders to make payment for shares of the Corporation theretofore purchased pursuant to this Agreement, upon the first to occur of the following:

15.1 The written Agreement of all the parties;

15.2 The dissolution, bankruptcy or insolvency of Corporation; or

15.3 At such time as only one Stockholder remains the shares of all others having been transferred or redeemed.

16. Ratification of Agreement. The Stockholders shall vote their stock so as to cause the Corporation to adopt and ratify all of the terms of this Agreement, and shall adopt such by-laws, resolutions and actions that will carry out the intent and meaning of this Agreement.

17. Arbitration. Any controversy arising under, out of, in connection with, or relating to this Agreement, and any amendments thereof, or the breach thereof, shall be determined and settled by arbitration in accordance with the rules then in existence of the American Arbitration Association and judgment upon the award rendered may be entered in any court having jurisdiction thereof.

18. Notices. Any notices, demand, election, offer, or other written instrument required or permitted to be given, made or sent hereunder shall be in writing, signed by the Stockholder giving or making the same, and shall be sent by registered mail to all Stockholders hereto and the Corporation simultaneously at

the following addresses:

ROBERT BOATWRIGHT
c/o [illegible] Clinical Laboratory
8820 Wilshire Boulevard
Beverly Hills, California 90211

SALVADOR LOYE

ROBERT SHMAEFF

GLEN E. CONLEY
c/o Glen-Tec Respiratory Service
P. O. Box 5323
San Bernardino, California 92404

STEPHEN K. MILLER
8383 Wilshire Boulevard
Suite 950
Beverly Hills, California 90211

LUDLOW B. CREARY, M.D.

THEODORE WOLF

Any notices, demand, offer, or other written instrument required to be given or sent to the estate of any deceased Stockholder shall be signed and sent, in like manner, addressed to the personal representative of such deceased Stockholder at his address, or, if there be no such personal representative, to the estate of the deceased Stockholder at his address hereinabove set forth. Any Stockholder hereto shall have the right to change the place to which any such notice, offer, demand, or writing shall be sent to him by a similar notice sent in the manner to all the Stockholders. The date of mailing of any offer, demand, notice, election or other instrument shall be deemed to be the date of such offer, demand, notice, election or other instrument and shall be effective from such date.

19. Entire Agreement. This Agreement constitutes the entire understanding of the Stockholders hereto with respect to the subject matter hereof, and no amendment, modification, or

BEST DOCUMENT AVAILABLE

alteration of the terms hereof shall be binding unless the same be in writing, dated subsequent to the date hereof and duly executed by all the parties; any such amendment, modification or alteration shall be effective and binding upon all parties as to execution.

20. Miscellaneous.

20.1 Each party hereto agrees to perform any further acts, vote his shares in any manner, and execute and deliver any documents which may be reasonable, necessary or desirable to carry out the provisions of this Agreement.

20.2 Each Stockholder agrees to insert in his Will a direction and authorization to his executor to fulfill and comply with the provisions hereof, and to sell his shares in accordance herewith, but the terms and provisions of this Agreement shall be binding and controlling despite the failure of any Stockholder to do so.

20.3 Upon any purchase by the Corporation of shares pursuant to this Agreement, the seller shall deliver to the Corporation for cancellation stock certificates evidencing the shares so purchased.

20.4 This Agreement shall not be construed to require any purchase of shares upon the death of the Stockholder last to die.

20.5 Reference in this Agreement to the masculine shall include the feminine and the neuter, references to the singular shall include the plural, and references to the plural shall include the singular, as the context may require.

20.6 Paragraph headings are for convenience only and shall not be used in construing this Agreement.

20.7 In the event any provision or provisions of this Agreement are or are for any reason adjudged to be unenforceable such provision or provisions shall be disregarded, and the remaining provisions hereof shall subsist and be carried into effect.

20.8 This Agreement is entered into under and shall be governed by the laws of the State of California.

20.9 In the event any action, suit, or proceeding is instituted under or in connection with this Agreement by any party hereto against any party hereto, the unsuccessful party therein agrees to pay the other party therein such attorneys' fees as the court or board of arbitration assuming jurisdiction may adjudge reasonable in such action, suit or proceeding.

20.10 This Agreement may be executed in any number of counterparts with the same effect as if all parties hereto have signed the same document. All counterparts shall be construed together and shall constitute one agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Pre-Incorporation Agreement as of the date first above written.

ROBERT BOATWRIGHT

SALVADOR NOYE

ROBERT SHEREFF

GLEN E. CONLEY

STEPHEN K. MILLER

LUDLOW B. CREARY, M.D.

Theodore Wolf

THEODORE WOLF

BEST DOCUMENT AVAILABLE

RATIFIED AND ADOPTED:

PERRIS VALLEY SCIENTIFIC

By Robt Boatwright
ROBERT BOATWRIGHT,
President

By ______________________________
ROBERT SHMAEFF,
Secretary

DATED: ______________________

ADOPTION, RATIFICATION AND CONSENT OF WIVES

We, the undersigned, do hereby acknowledge that we have carefully read the foregoing Agreement, executed as of the _____ day of ________________, 197_, by and between ROBERT BOATWRIGHT, SALVADOR MOYE, ROBERT SHMAEFF, GLEN E. CONLEY, STEPHEN K. MILLER, LUDLOW B. CREARY, M.D., and THEODORE WOLF, and understand its meaning and effect; we fully and freely consent to and approve its purposes and its provisions; that we do hereby subject to the terms thereof any community property interest that we may now or hereafter have in any property therein referred to, and that we promise and agree to execute any and all instruments and to do any and all things necessary or proper to accomplish the purpose set forth in said Agreement. We, and each of us, do hereby appoint our respective husbands our attorneys-in-fact for the purpose of modifying, amending, supplementing or terminating this Agreement, and we, and each of us, do hereby authorize, approve, ratify, confirm and adopt any such modification, amendment, supplement or termination as may at any time and from time to time be made by our husbands. We, and each of us, hereby agree that we are and shall be bound by the terms and conditions of said Agreement as surviving spouse, heir, legatee, executrix and/or administratrix, in the event that we shall survive our respective husbands.

DATED: This _____ day of _____________, 197_.

MRS. ROBERT BOATWRIGHT

MRS. SALVADOR MOYE

MRS. ROBERT SCHAEFF

Mrs. Glen E. Conley

MRS. GLEN E. CONLEY

MRS. STEPHEN K. MILLER

MRS. LUDLOW B. CREARY

MRS. THEODORE WOLF

Appendix B

PROMISSORY NOTE
SECURED BY SECURITY AGREEMENT

$ 210,000.00 Perris, California December 29, 1976

In installments as herein stated, for value received, the undersigned promises to pay to PERRIS VALLEY SCIENTIFIC, a California corporation, or order, at Perris, California, or place designated, the sum of TWO HUNDRED TEN THOUSAND DOLLARS, with interest from date on unpaid principal at the rate of nine per cent (9%) per annum; principal and interest payable in installments of $4,490.00 or more on the first day of each month beginning on the first day of May, 1977, and continuing until paid.

Each payment shall be credited first on interest then due and the remainder on principal; and interest shall thereupon cease upon the principal so credited. Should default be made in payment of any installment when due the whole sum of principal and interest shall become immediately due at the option of the holder of this note. Principal and interest payable in lawful money of the United States. If action be instituted on this note, the undersigned promises to pay such sum as the Court may fix as attorneys' fees. This note is secured by a Security Agreement.

COMMUNITY HOSPITAL OF THE VALLEYS,
A California Nonprofit Corporation

By: ______________________
STEPHEN K. HILLER, President

By: ______________________
LUDLOW B. CREARY, Secretary

SECURITY AGREEMENT

COMMUNITY HOSPITAL OF THE VALLEYS, a California nonprofit corporation, hereinafter sometimes called "Debtor", and PERRIS VALLEY SCIENTIFIC, a California corporation, hereinafter sometimes called "Secured Party", in consideration of the promises made herein and intending to be legally bound, agree as follows:

1. Debtor is a nonprofit corporation duly organized, validly existing, and in good standing under the laws of the State of California, with corporate power to own property and carry on its business as it is now being conducted. Debtor has its principal office and place of business in the County of Riverside, State of California. Debtor keeps its records concerning accounts and contract rights in the County of Riverside, State of California.

2. Secured Party is a corporation duly organized, validly existing, and in good standing under the laws of the State of California, with corporate power to own property and carry on its business as it is now being conducted. Secured Party has its principal office and place of business in the County of Riverside, State of California.

3. Debtor acknowledges receipt of the sum of Two Hundred Ten Thousand Dollars ($210,000.00) from Secured Party and agrees to repay the same in accordance with the certain Promissory Note bearing the date of December 29, 1976. Further, Debtor acknowledges that it has or will enter into an ancillary service agreement with Secured Party, pertaining to the

terms and provisions of which Secured Party shall provide Debtor with such ancillary services, including pharmacy, laboratory, respiratory therapy and cardiopulmonary laboratory, physical therapy, and similar services, and shall provide for the rendering of radiological services. Further, Secured Party will bill Debtor for the value of such services rendered on behalf of Debtor, and said items shall be referred to hereinafter as the "fees receivable".

4. As collateral security for the repayment of said Promissory Note, and fees receivable, Debtor assigns and grants a security interest to Secured Party in all presently existing and hereafter arising accounts receivable, instruments, documents, chattel paper, general intangibles, and all other forms of obligations owing to Debtor, equipment, inventory, money, and deposit accounts and any and all other tangible and intangible property of Debtor, including proceeds derived therefrom, and all proceeds of insurance, all guarantees and other security therefor.

5. Debtor shall execute and deliver to Secured Party concurrently with Debtor's execution of this Agreement, and at any time or times hereafter at the request of Secured Party, all financing statements, continuation financing statements, security agreements, mortgages, assignments, memoranda of security interest, certificates of title, affidavits, reports, notices, schedules of accounts, letters of authority, and all other documents that Secured Party may request, in form satisfactory to Secured Party, to perfect and maintain perfected Secured Party's security interest in the collateral as defined in the previous paragraph, and in order to fully

consummate all of the transactions contemplated under this Agreement.

6. So long as Debtor is indebted to Secured Party, Debtor warrants, represents and agrees that:

A. Debtor's sole place of business or chief executive office or residence is located in the County of Riverside, State of California, and Debtor covenants and agrees that it will not, during the term of this Agreement, without prior written notification to Secured Party, relocate said sole place of business or chief executive office or residence.

B. Debtor represents and warrants and covenants with Secured Party that Debtor will not, without Secured Party's prior written consent: (1) grant a security interest in or permit a lien claim or encumbrance upon any of the collateral to any person, association, firm, corporation, entity, or governmental agency or instrumentality; (2) permit any levy, attachment or restraint to be made effecting any of the Debtor's assets; (3) permit any judicial officer or assignee to be appointed or to take possession of any or all of Debtor's assets; (4) other than in the ordinary course of Debtor's business, to sell, lease, or otherwise dispose of, move, or transfer, whether by sale or otherwise, any of Debtor's assets; (5) change its name, business structure, corporate entity or structure; add any new fictitious name; liquidate, merge or consolidate with or into any other business organization; (6) move or relocate any collateral; (7) acquire any other business organization; (8) enter into any transaction not in the usual course of Debtor's business; (9) make any investment in securities of any person, association, firm, entity or corporation other than the securities of the United States government; (10) guarantee or otherwise become in any way liable with respect to the obligations of any person, firm, association, entity, of payment for deposit to the general account of Debtor or which were transmitted or turned over to Secured Party on account of Debtor's obligations; (11) make any change in borrower's financial structure or in any of its business objectives, purpose or operations, which would adversely affect the ability of Debtor to repay Debtor's obligations to Secured Party; (12) incur any debts outside the ordinary course of Debtor's business except renewals or extentions of existing debts and interest thereon; (13) make any advance or loan except in the ordinary course of business as presently conducted; (14) pay total compensation, including salaries, withdrawals, fees, bonuses, commissions, drawing accounts, and other payments whether directly or indirectly, in money or otherwise, during any fiscal year, to all of Debtor's executives, officers, and directors in an unreasonable amount, and in no event in an aggregate amount in excess of 115% of those paid in the prior fiscal year; (15) make any planned or fixed capital expenditure, or any commitment therefor, or purchase or lease any real or personal property replacement equipment subject to a purchase money security interest, trust deed or lease in any one fiscal year in excess of its annual allocation to depreciation reserves.

7. Debtor warrants and represents that it presently holds title, to the aforementioned collateral, and this Security Agreement shall attach to any and all right, title and interest that the Debtor may have or may hereafter acquire in such collateral.

8. Debtor warrants and represents that it is and shall at all times hereafter be a nonprofit corporation duly organized and existing in good standing under the laws of the State of California and qualified and licensed to do business in California or any other state in which it conducts business.

9. Debtor warrants and represents that it has the right and power and is duly authorized to enter into this Agreement.

10. Debtor warrants and represents that the execution by Debtor of this Agreement shall not constitute a breach of any provision contained in Debtor's Articles of Incorporation or By-Laws or any contained in any agreement to which Debtor is now or hereafter becomes a party.

11. Any one or more of the following events shall constitute a default by Debtor under this Agreement:

A. If Debtor fails or neglects to perform, keep or observe any term, provision, condition, covenant, agreement, warranty or representation contained in this Agreement, or any other present or future agreement between Debtor and Secured Party.

B. If any representation, statement, report or certificate made or delivered by Debtor, or any of its officers, employees or agents to Secured Party is not true and correct.

C. If Debtor fails to pay when due and payable or declared due and payable, any installment, whether of principal or interest, of the subject promissory note.

D. If there is a material impairment of the prospect of repayment of Debtor's obligations, or a material impairment of the value of priority of Secured Party's security interest.

E. If any or all of Debtor's assets are attached, siezed, subjected to a writ or distress warrant, or levied upon, or come into the possession of any judicial officer or assignee, and the same are not released, discharged or bonded against within ten (10) days thereafter.

F. If an insolvency proceeding is commenced by or against Debtor.

G. If any proceedings filed or commenced by or against Debtor for its dissolution or liquidation.

H. If Debtor is enjoined, restrained or in any way prevented by court order from continuing to conduct all or any material part of its business affairs.

I. If a notice of lien, levy or assessment is filed of record with respect to any or all of Debtor's assets by the United States government, or any department, agency or instrumentality thereof, or by any state, county, municipal or other governmental agency, or if any taxes or debts owing at any time hereafter to any one or more of such entities becomes a lien, whether choate, or otherwise, upon any or all of the Debtor's assets.

J. If a judgment or other claim becomes a lien or encumbrance upon any or all of Debtor's assets and the same is not satisfied, dismissed or bonded against within ten (10) days thereafter.

K. If Debtor permits a default of any agreement to which Debtor is a party with third parties so as to result in an accelleration of the maturity of Debtor's indebtedness to others, whether under any indenture, agreement or otherwise.

L. If Debtor makes any payment on account of indebtedness which has been subordinated to Debtor's obligations to Secured Party.

M. If any misrepresentation exists, now or hereafter, any warranty or representation made by any officer or director individually, or as an officer or director of Debtor, or if any such warranty representation is withdrawn by an officer or director.

12. In the event of a default by Debtor under this Agreement, Secured Party may, at its election, without notice of its election and without demand, do any one or more of the following, all of which are authorized by Debtor:

A. Declare Debtor's obligations under the subject promissory note immediately due and payable.

B. Without notice to or demand upon Debtor or any guarantor, make such payments and do such acts as Secured Party considers necessary or reasonable to protect its security interest in the collateral. Debtor authorizes Secured Party to enter the premises where the collateral is located, take possession of the collateral, or any part of it, and to pay, purchase, contest or compromise any encumbrance, charge or lien which in the opinion of Secured Party appears to be prior or superior to its security interest and to pay all expenses incurred in connection therewith.

C. Sell the collateral at either a public or private sale, or both, by way of one or more contracts or transactions, for cash or on terms, in such manner and at such prices as is commercially reasonable in the opinion of Secured

Party. It is not necessary that the collateral be present at such sale.

D. Secured Party shall give notice that the deposition of the collateral as follows:

(1) Secured Party shall give the Debtor and each holder of a security interest in the collater who has filed with the Secured Party a written request for notice, a notice in writing of the time and place of public sale, or, if the sale is a private sale, or some other disposition other than a public sale is to be made of the collateral, the time on or after which the private sale or other disposition is to be made.

(2) The notice shall be personally delivered or mailed, postage prepaid, to Debtor's address appearing on this Agreement, or such other address as designated in writing by Debtor, at least five (5) days before the date fixed for sale, or at least five (5) days before the date on or after which the private sale or other disposition is to be made, unless the collateral is perishable or threatened to decline speedily in value. Notice to persons other than Debtor claiming an interest in the collateral shall be sent to such addresses as they have furnished to Secured Party.

(3) If the sale is to be public sale, Secured Party shall also give notice of the time and place by publishing a notice one time at least

ten (10) days before the date of the sale in a newspaper of general circulation in the county in which the sale is to be held.

(4) Secured Party may purchase at any public sale.

E. Debtor shall pay all costs incurred in connection with the Secured Party's enforcement, and exercise of any of its rights and remedies as herein provided, whether or not suit is commenced by Secured Party.

F. Any deficiency which exists after disposition of the collateral as provided above, will be paid immediately by Debtor. Any excess will be returned to Debtor by Secured Party.

13. Secured Party's rights and remedies under this Agreement and all other security agreements shall be cumulative. Secured Party shall have all other rights and remedies not inconsistent herewith as provided by law or in equity. No exercise by Secured Party of one right or remedy shall be deemed an election, and no waiver by Secured Party of any default on Debtor's part shall be deemed a continuing waiver. No delay by Secured Party shall constitute a waiver, election, or acquiescence by it.

14. Debtor and Secured Party waive any right to trial by jury in any action or proceeding relating to this Agreement, or any transactions hereunder.

15. This Agreement shall be binding and deemed effective when executed by Debtor and accepted and executed by Secured Party.

16. This Agreement shall bind and inure to the bene-

fit of the respective successors and assigns of each party; however, Debtor may not assign this Agreement or any rights hereunder without Secured Party's prior written consent, and any prohibited assignment shall be absolutely void. No consent to an assignment by Secured Party shall release Debtor or any guarantor of their obligations to Secured Party. Secured Party may assign this Agreement and its rights and duties hereunder.

17. Neither this Agreement nor any uncertainty or ambiguity herein shall be construed or resolved against Secured Party or Debtor, whether under any rule of construction or otherwise; on the contrary, this Agreement has been reviewed by all parties and shall be construed and interpreted according to the ordinary meaning of the words used so as to fairly accomplish the purpose and intentions of all parties hereto. When permitted by the context, the singular includes the plural, and vice versa.

18. The validity of this Agreement, its construction, interpretation and enforcement, and the rights of the parties hereunder and concerning the collateral, shall be determined under and according to the laws of the State of California.

19. Each provision of this Agreement shall be severable from every other provision of this Agreement for the purpose of determining the legal enforceability of any specific provisions.

20. This Agreement cannot be changed or terminated orally. All prior agreements, understandings, representations, warranties, and negotiations, if any, are merged into this Agreement.

21. The parties intend and agree that their respective rights, duties, powers, limitations, obligations and discretions shall be performed, carried out, discharged and exercised reasonably and in good faith.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed at Perris, California, this 29th day of December, 1976.

COMMUNITY HOSPITAL OF THE
VALLEYS, a California
nonprofit corporation

By: ______________________
STEPHEN K. MILLER
President

By: ______________________
LUDLOW B. CREARY
Secretary

"DEBTOR"

PERRIS VALLEY SCIENTIFIC,
A California corporation

By: ______________________
ROBERT BO[illegible]WRIGHT
President

By: ______________________
ROBERT SHMAEFF
Secretary

"SECURED PARTY"

This FINANCING STATEMENT is presented for filing pursuant to the California Uniform Commercial Code.

1. DEBTOR (LAST NAME FIRST—IF AN INDIVIDUAL) COMMUNITY HOSPITAL OF THE VALLEYS	1A. SOCIAL SECURITY OR FEDERAL TAX NO. PENDING
1B. MAILING ADDRESS 2224 RUBY DRIVE	1C. CITY, STATE PERRIS, CALIFORNIA — 1D. ZIP CODE 92370
2. ADDITIONAL DEBTOR (IF ANY) (LAST NAME FIRST—IF AN INDIVIDUAL)	2A. SOCIAL SECURITY OR FEDERAL TAX NO.
2B. MAILING ADDRESS	2C. CITY, STATE — 2D. ZIP CODE
3. DEBTOR'S TRADE NAMES OR STYLES (IF ANY) COMMUNITY HOSPITAL	3A. FEDERAL TAX NUMBER PENDING
4. SECURED PARTY NAME PERRIS VALLEY SCIENTIFIC MAILING ADDRESS 2224 RUBY DRIVE CITY PERRIS STATE CALIFORNIA ZIP CODE 92370	4A. SOCIAL SECURITY NO., FEDERAL TAX NO. OR BANK TRANSIT AND A.B.A. NO. PENDING
5. ASSIGNEE OF SECURED PARTY (IF ANY) NAME MAILING ADDRESS CITY STATE ZIP CODE	5A. SOCIAL SECURITY NO., FEDERAL TAX NO. OR BANK TRANSIT AND A.B.A. NO.

6. This FINANCING STATEMENT covers the following types or items of property (include description of real property on which located and owner of record when required by instruction 4).

All presently existing and hereafter arising accounts receivable, instruments, documents, chattel paper, general intangibles, and all other form of obligations owing to Debtor, equipment, inventory, money and deposit accounts and any and all other tangible and intangible property of Debtor, including proceeds derived therefrom, and all proceeds of insurance; all guarantees and other security therefor.

7. CHECK IF APPLICABLE ☒ 7A. ☐ PRODUCTS OF COLLATERAL ARE ALSO COVERED

7B. DEBTOR(S) SIGNATURE NOT REQUIRED IN ACCORDANCE WITH INSTRUCTION 5(a) ITEM: ☐ (1) ☐ (2) ☐ (3) ☐ (4)

8. CHECK IF APPLICABLE ☒ ☐ DEBTOR IS A "TRANSMITTING UTILITY" IN ACCORDANCE WITH UCC § 9105 (1) (n)

9. DATE: 12/29/76

, President Ludlow B. Creary M.D.

SIGNATURE(S) OF DEBTOR(S)

~~COMMUNITY HOSPITAL OF THE VALLEYS~~ A California Non-Profit Corporation, By Stephen K. Miller, President and Ludlow B. Creary, M.D., Secretary

TYPE OR PRINT NAME(S) OF DEBTOR(S)

Robert Boatwright, President

SIGNATURE(S) OF SECURED PARTY(IES)

PERRIS VALLEY SCIENTIFIC, a California Corporation, by Robert Boatwright, President and Robert Shnaeff, Secretary

TYPE OR PRINT NAME(S) OF SECURED PARTY(IES)

10. THIS SPACE FOR USE OF FILING OFFICER (DATE, TIME, FILE NUMBER AND FILING OFFICER)

77037039
FILED
SACRAMENTO, CALIF.
MAR 14 1977 11 [illegible]
MARCH FONG EU
SECRETARY OF STATE

11. Return copy to:

NAME RUBIN AND MILLER, A Prof. Corporation
ADDRESS 8383 Wilshire Boulevard, Suite 950
CITY Beverly Hills, California 90211
STATE
ZIP CODE

Filing Officer is requested to note file number, date and hour of filing on this copy and return to the above party.

(2) FILING OFFICER COPY—ACKNOWLEDGMENT

FORM UCC-1 — Filing Fee $3.00
Approved by the Secretary of State

BEST DOCUMENT AVAILABLE

ASSIGNMENT OF LEASE AS COLLATERAL SECURITY

For value received, the undersigned, COMMUNITY HOSPITAL OF THE VALLEYS, a California nonprofit corporation, Lessee in that certain lease dated December 22, 1976, executed by and between PERRIS VALLEY COMMUNITY HOSPITAL, LTD., a limited partnership, as Lessor, and COMMUNITY HOSPITAL OF THE VALLEYS, as Lessee, covering premises known as 2224 North Ruby Drive, Perris, California, does hereby assign and transfer all right, title and interest in and to said lease to PERRIS VALLEY SCIENTIFIC, a California corporation, holder of that certain promissory note dated December 29, 1976, as collateral security therefor.

It is understood that the holder of said note shall not exercise any rights as Lessee unless and until the undersigned shall be in default under the terms of said note or the abovementioned lease.

Following a default under the note and/or lease, the assignee at his election, may treat the undersigned as his agent or licensee with respect to the latter's occupancy of the premises, and the parties acknowledge that the assignee may bring unlawful detainer proceedings should the undersigned fail to surrender possession upon demand.

This assignment shall become null and void upon payment in full of all obligations of the undersigned to the holder of said note.

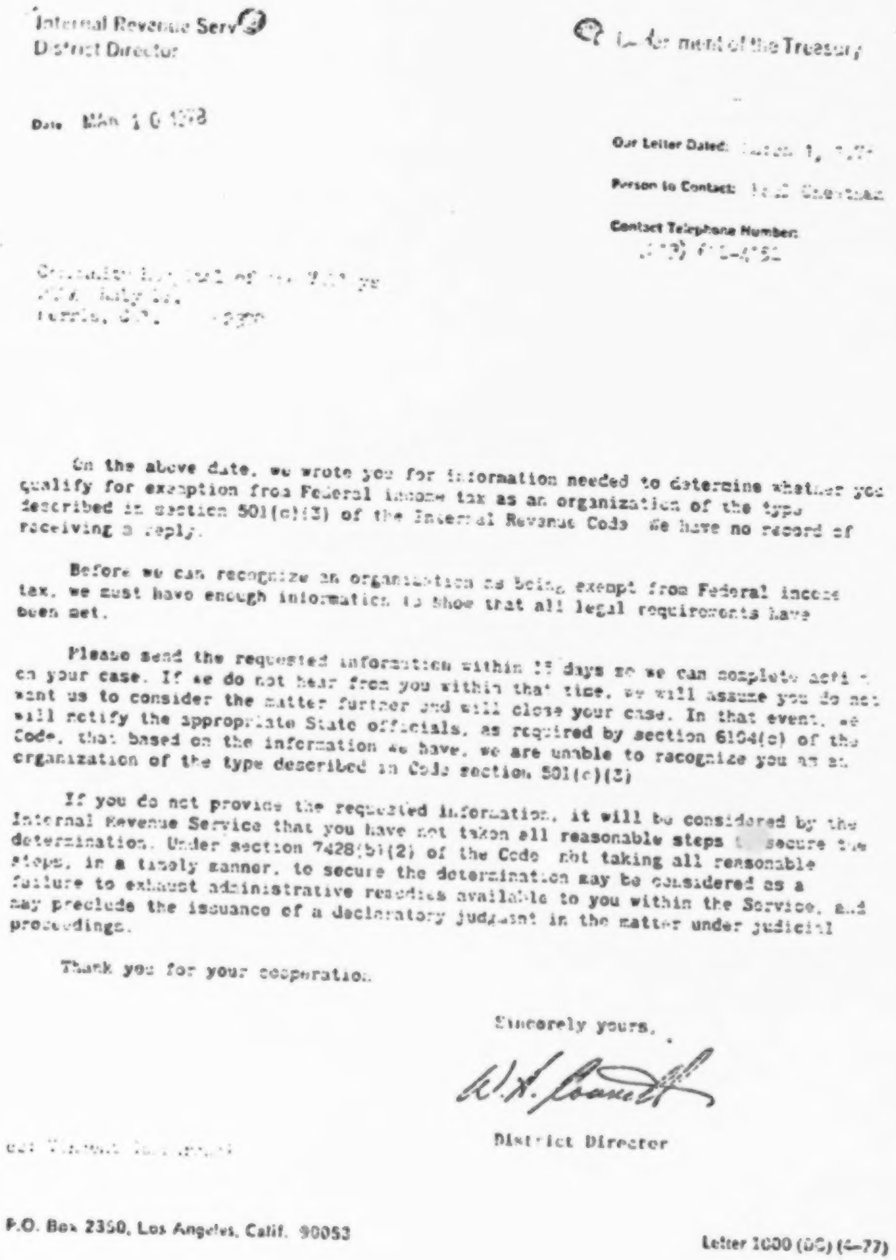
Dated this 29th day of December, 1976.

COMMUNITY HOSPITAL OF THE VALLEYS
A California Nonprofit Corporation

By: ______________________
STEPHEN K. MILLER, President

By: ______________________
LUDLOW H. CREARY, Secretary

Appendix C



Internal Revenue Service
District Director

Department of the Treasury

Date MAR 1 0 1978

Our Letter Dated: [illegible] 1, [illegible]

Person to Contact: [illegible]

Contact Telephone Number:
[illegible]

[illegible]
[illegible]
[illegible]

On the above date, we wrote you for information needed to determine whether you qualify for exemption from Federal income tax as an organization of the type described in section 501(c)(3) of the Internal Revenue Code. We have no record of receiving a reply.

Before we can recognize an organization as being exempt from Federal income tax, we must have enough information to show that all legal requirements have been met.

Please send the requested information within 15 days so we can complete action on your case. If we do not hear from you within that time, we will assume you do not want us to consider the matter further and will close your case. In that event, we will notify the appropriate State officials, as required by section 6104(c) of the Code, that based on the information we have, we are unable to recognize you as an organization of the type described in Code section 501(c)(3)

If you do not provide the requested information, it will be considered by the Internal Revenue Service that you have not taken all reasonable steps to secure the determination. Under section 7428(b)(2) of the Code not taking all reasonable steps, in a timely manner, to secure the determination may be considered as a failure to exhaust administrative remedies available to you within the Service, and may preclude the issuance of a declaratory judgment in the matter under judicial proceedings.

Thank you for your cooperation.

Sincerely yours,

W. H. Connett

District Director

cc: [illegible]

P.O. Box 2350, Los Angeles, Calif. 90053

Letter 1000 (DO) (4-77)

Internal Revenue Service
District Director

Department of the Treasury

Date: MAR 0 1 1978

Form Number:
1023
Person to Contact:
[illegible]
Contact Telephone Number:
(213) [illegible]

Community Hospital of the Valley
2224 Ruby Drive
Perris, California 92370

To help us determine whether your organization is exempt from Federal income tax, please send us the information asked for in the block checked below.

☐ Complete the following items on the enclosed forms:

☐ Furnish the information requested in the following items on the enclosed forms:

☐ Complete the enclosed forms.

☒ Please submit the information requested on the attached [illegible].

Please provide this information by [arch 10, 197]. and attach the copy of this letter to your reply. An addressed envelope is enclosed for your convenience.

P.O. Box 2350, Los Angeles, Calif. 90053

Letter 598(DO) (5-77)

BEST DOCUMENT AVAILABLE

If your organization will be represented by an agent or attorney, you will need to file the necessary authorization if you have not already done so. Form 2848, Power of Attorney, and Form 2848-D, Authorization and Declaration, are available at any Internal Revenue Service office.

If you are an organization described in section 501(c)(3) of the Internal Revenue Code and do not provide the requested information, it will be considered by the Internal Revenue Service that you have not taken all reasonable steps to secure the determination. Under section 7428(b)(2) of the Code, not taking all reasonable steps, in a timely manner, to secure the determination may be considered as a failure to exhaust administrative remedies available to you within the Service, and may preclude the issuance of a declaratory judgment in the matter under judicial proceedings.

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Thank you for your cooperation.

Sincerely yours,

W. H. Connett

District Director

Enclosures:
Application forms
Copy of this letter
Envelope

m.

Community Hospital of the Valleys
Attachment

1. Revenue Ruling 69-545 (copy enclosed) illustrates whether a nonprofit hospital claiming exemption under a section 501(c)(3) of the Code is operated to serve a public rather than a private interest. Two important mentioned in this ruling are:

   A. That at least 50% of the Board of Directors must consist of independent, civic-minded individuals who will be actively involved in the control and direction of the organization. The fact that only two of your five Directors are medical personnel suggests that you will have no difficulty complying with this requirement. However, it will be helpful if you would acknowledge a continuing willingness to maintain this policy.

   B. There must be an open staffing policy. Open staffing means that the professional people providing services are not limited to just a few individuals (for example, the founders of the organization). Rather, it means that any qualified, community-minded professional could be active in helping the organization carry out its intended purposes. Please acknowledge your intentions to do this.

2. List each employee by name. State the amount of compensation each will receive and the basis for arriving at these amounts.

3. Please submit copies of any brochures, pamphlets, newsletters, advertisements or any other literatureregarding your organization.

4.Provide copies of any written leases, contracts, or agreements entered into by your organization.

5. Did you consider entering into agreements with other organizations besides Medical Environments, Inc., Perris Valley Scientific, and Perris Valley Community Hospital, Ltd. ? If yes, list the other organizations and explain why their terms were not acceptable. If no, please explain why other organizations were not considered.

6. Does anyone associated with the hospital have a financial interest in any of the organizations which have contracts and agreements with the hospital? If yes, describe this financial interest fully. In addition, you should explain why you believe the amounts negotiated for goods and services are fair and reasonable.

7. The end of your fical year as specified in your bylaws differs from the date shown on your application. Please advise us of the correct year and date.

COMMUNITY HOSPITAL
of the VALLEYS

2224 RUBY DRIVE
PERRIS, CALIFORNIA 92370

(714) 657-7381

May 11, 1978

INTERNAL REVENUE SERVICE
P. O. Box 2350
Los Angeles, California 90053

Attention: Paul Cheatham

Re: Community Hospital of the Valleys
2224 Ruby Drive
Perris, California 92370

Form 1023

Gentlemen:

The following information is submitted in accordance with your request dated March 1, 1978, a copy of which is enclosed for your reference.

1. It is the hospital's express policy to maintain a board of directors consisting predominantly of independent, civic-minded individuals. Please note that one of the two medical personnel who were acting as directors of the hospital, namely Dr. Lenaires Johnson, is no longer a director of the hospital. Therefore, of the existing board of directors, consisting of five individuals, only one individual is a physician on the staff of the hospital. Accordingly, the board of directors currently is composed in majority by local, respected people who have no interest in any entity involved with the hospital, and it is the hospital's intention to maintain this local control. Further, with reference to the second subcategory under Paragraph 1 of your letter, medical staff privileges of the hospital are available to all qualified physicians in the area, and, in fact, substantial effort has and is being undertaken to encourgage local physicians to apply for and utilize membership in the medical staff of the hospital.

2. In lieu of providing the list of each employee by name, please be advised that employees are hired based on wage scales developed by the hospital by reference to compensation paid by other hospitals in the Riverside, San Bernardino and Redlands area. Clerical and other non-medical type positions are paid at prevailing rates for similar jobs in the area. Increases and adjustments will be based on current practices in the industry.

A NOT FOR PROFIT COMMUNITY HOSPITAL

3. See the attachments enclosed herewith.

4. See the attachments enclosed herewith.

5. The hospital did not consider entering into agreements with other organizations besides Medical Environments, Inc.; Perris Valley Scientific; and Perris Valley Community Hospital, Ltd. The reason for this has to do with the history of this hospital. This facility, under the name of Perris Valley Community Hospital, opened in 1972 as a proprietary hospital, which went into bankruptcy in 1974. During the course of the bankruptcy proceeding, a junior mortgage holder of the hospital was permitted leave to foreclose his mortgage, and thereupon became record holder of the hospital facility. Following the foreclosure, the limited partnership known as Perris Valley Community Hospital, Ltd., was formed, which limited partnership leased the facility to Lakeview Hospital, a California corporation. Lakeview Hospitaloperated this hospital for approximately 1-1/2 years, and then abandoned its leasehold interest in the hospital. Thus, in the short period of time in which this hospital was operated, there had been two failures by the operating entities, thereby depriving the City of Perris, and the surrounding communities of the medical facilities theretofore provided by the hospital.

During the end of 1976, a group of individuals was formed for the purpose of re-opening the hospital as a nonprofit community hospital so that the management and control of the hospital could be controlled by the local community itself. This group,known as Perris Valley Scientific, a California corporation, financed the re-opening of the hospital by loaning to the nonprofit corporation a sum in excess of Two Hundred Thousand Dollars ($200,000) as working capital. This loan is still outstanding, and in fact, although payments were intended to be made on the note so as to amortize it over five years, no payments have yet beenmade, and indeed, no payments have been demanded. Concurrent with the loan to Community Hospital of the Valleys by Perris Valley Scientific, the two entities entered into an agreement whereby Perris Valley Scientific agreed to perform the ancillary services necessary for the hospital, including laboratory, pharmacy, inhalation therapy, and the like, which agreement provided that payments to be made to Perris Valley Scientific were solely as a percentage of billings for work performed, with no guaranteed minimum. This agreement also provided that the ancillary services to be performed were to be billed at the prevailing rates for similar services performed in the area, and hence this agreement was truly an arms-length transaction in all respects. At the request of Perris Valley Scientific, Community Hospital of the Valleys employed the services of Medical Environments to act as administration for the hospital, based upon the reputation and ability of Medical Environments to competently run the hospital for the nonprofit corporation, and for which Medical Environments charged the normal management fee for similar services rendered in similar communities. Other than this management agreement, Medical Environments has no interest in the hospital or in Perris Valley Scientific.

6. Yes. The undersigned is a director and president of Community Hospital of the Valleys and also owns approximately 12% of the equity of Perris Valley Scientific, which latter interest was obtained by purchase for a pro rata portion of the $210,000 initially loaned to Community Hospital of the Valleys by Perris Valley Scientific. No other person, firm, and/or entity associated with the hospital has any financial interest in any or the organizations which have contracts and agreements with the hospital, except that Dr. Charles Gordon is a director and secretary of Community Hospital of the Valleys, and is also a member of the medical staff of the hospital. However, Dr. Gordon has no interest in Perris Valley Scientific, Medical Environments, or any other entity. Finally, all agreements entered into by the Community Hospital of the Valleys specifically requires that the charges for goods and services rendered to Community Hospital of the Valleys shall be at the prevailing rates for similar goods and services in similar locations.

7. It was decided to change the fiscal year of Community Hospital of the Valleys after the original application was submitted, and the fiscal year of the corporation is the calendar year.

I trust this supplies the information requested. Should any further information be required, please do not hesitate to contact me at your convenience.

Very truly yours,

Stephen K. Miller
President

SKM/ag

Appendix D

MINUTES OF FIRST MEETING OF
THE DIRECTOR(S) OF

COMMUNITY HOSPITAL OF THE VALLEYS
a California corporation (Nonprofit)

The one or more director(s) named in the Articles of Incorporation of the above named corporation, constituting the Board of Directors of said corporation, held the first meeting thereof at the time, on the day and at the place set forth as follows:

TIME: 10:00 A.M.

DATE: December 27, 1976

PLACE: Law Offices of Rubin and Miller
8383 Wilshire Boulevard, Beverly Hills, CA 90211

Present at the meeting and constituting a quorum of the full board, were the following named person(s):

STEPHEN K. MILLER
SHARON BRUNNER
VICKI CIPPARRONE

On Motion and by unanimous vote, the following named persons were elected temporary chairman and secretary of the first meeting:

Temporary Chairman: STEPHEN K. MILLER

Temporary Secretary: SHARON BRUNNER

WAIVER

The chairman announced that the meeting was held pursuant to written waiver of notice thereof and consent thereto signed by all of the directors of the corporation named as such in the Articles of Incorporation; such waiver and consent was presented to the meeting and upon motion duly made, seconded and unanimously carried was made a part of the records of the meeting and now precedes the minutes of this meeting in the Book of Minutes of the corporation.

ARTICLES FILED

The chairman stated that the original Articles of Incorporation of the corporation had been filed in the office of the California Secretary of State in Sacramento, and that a certified copy thereof

WAIVER OF NOTICE AND CONSENT TO HOLDING OF FIRST MEETING OF DIRECTORS OF

COMMUNITY HOSPITAL OF THE VALLEYS
A California Nonprofit Corporation

The undersigned, being all of the directors named in the Articles of Incorporation, desiring to hold the first meeting of the Board of Directors of said corporation for the purpose of completing the organization of its affairs, DO HEREBY waive notice of said meeting and consent to the holding thereof, at the time, on the day and at the place set forth as follows:

TIME: 10:00 A.M.

DATE: December 27, 1976

PLACE: Law Offices of Rubin and Miller
8383 Wilshire Boulevard
Beverly Hills, California 90211

Said meeting is to be held for the purpose of adopting By-Laws, electing officers, adopting a form of corporate seal, selecting an accounting year, establishing a bank account, and transacting such other business as may be brought before said meeting; and do further agree that any business transacted at said meeting shall be as valid and legal and of the same force and effect as though said meeting were held after notice duly given.

EXECUTED at the time, place and date first above written, unless otherwise indicated after each signature.

STEPHEN K. MILLER

Sharon Brunner
SHARON BRUNNER

Vicki Cipparone
VICKI CIPPARRONE

ACCOUNTING YEAR

The chairman suggested that the meeting consider the adoption of an accounting year, either fiscal or calendar, so that the Franchise Tax Board could be notified thereof. On motion duly made, seconded and unanimously carried, the following resolution was adopted:

> RESOLVED, that this corporation adopt an accounting year as follows:
>
> DATE ACCOUNTING YEAR BEGINS: February 1 of each year
>
> DATE ACCOUNTING YEAR ENDS: January 31 of each year

INCORPORATION EXPENSES

In order to provide for the payment of the expenses of incorporation and organization of the corporation, on motion duly made, seconded and unanimously carried, the following resolution was adopted:

> RESOLVED, that the president or vice-president and the treasurer of this corporation be, and they hereby are, authorized and directed to pay the expense of the incorporation and organization of this corporation.

PRINCIPAL OFFICE LOCATION

After some discussion, the location of the principal office of the corporation for the transaction of the business of the corporation was fixed pursuant to the following resolution unanimously adopted, upon motion duly made and seconded:

> RESOLVED, that the county named in the Articles of Incorporation be and the same is hereby designated and fixed as the county in which the principal office for the transaction of the business of this corporation shall be located until changed by subsequent resolution of this Board.

BANK RESOLUTION

To provide for a depository for the funds of the corporation and to authorize certain officers to deal with the corporate funds, the following resolutions were duly adopted:

RESOLVED, that this corporation open an account or accounts with the following named bank:

RESOLVED FURTHER, that until such authority is revoked by sealed notification to said bank of such action by the Board of Directors of this corporation,

Name of Officer: Office Held:

______________________________ ____________________

______________________________ ____________________

______________________________ ____________________

______________________________ ____________________

be, and they are authorized ______________________
(Insert: "Any One Acting
____
Alone," "Acting Together," "Any Two Acting Together," etc., as the case may be)

to execute checks and other items for and on behalf of this corporation.

FURTHER RESOLVED, that said account shall be governed by applicable banking laws, customs and Clearing House regulations and by the rules printed in the bank book, and shall be subject to the service charge schedule of the bank. If this is a checking account, the bank is requested to prepare and dispose of statements and cancelled checks monthly as instructed below. The bank assumes all risk of loss in transit of any statement or check.

Statement Instructions: Bank is instructed to:

(MAIL)_____ to the statement mailing address shown on the bank records.

(HOLD UNTIL CALLED FOR)_____ If not called for within 10 days after preparation, the Bank may forward the statement and cancelled checks by ordinary mail, bank messenger or other reasonable means to the statement mailing address shown on the bank records.

Office	Name	Monthly Salary (if known)
President	STEPHEN K. MILLER	$
Vice President	HOWARD S. KAATZ	$
Treasurer		$
Secretary	LUDLOW B. CREARY, M.D.	$
Asst. Secretary		$

Each officer so elected being present accepted his office, and thereafter the president presided at the meeting as chairman and the secretary acted as secretary of the meeting.

CORPORATE SEAL

The secretary presented for the approval of the meeting a proposed seal of the corporation, consisting of two concentric circles with the name of the corporation in one circle and the words and figures, "INCORPORATED", the date of incorporation, and "CALIFORNI[illegible] in the form and figures as follows;

(SEAL)

On motion duly made, seconded and unanimously carried, the following resolution was adopted:

> RESOLVED, that the corporate seal in the form, words and figures presented to this meeting be and the same hereby is adopted as the seal of this corporation.

~~SHARE CERTIFICATE~~

~~The [illegible] presented to the meeting a proposed form of share [illegible] by the corporation [illegible] motion duly [illegible] the following resolution was adopted:~~

> ~~RESOLVED, that the form of share [illegible] presented [illegible] be and the same hereby [illegible] the [illegible] of this corporation.~~

~~The [illegible] in the book of [illegible] following the minutes of this meeting.~~

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had been filed in the office of the County Clerk of the county named in the Articles as being the county in which the corporation is to have its principal office, as follows:

Date of filing Articles in Sacramento: December 8, 1976

Date of filing Articles in County:

The chairman further stated that a copy of said articles, similarly certified, had been filed in the office of each county in the State of California in which the corporation holds, or contemplates holding, real property. He presented to the meeting a certified copy of said Articles of Incorporation, showing filings as stated, and the secretary was directed to insert said copy in the Book of Minutes of the corporation.

BY-LAWS

The matter of the adoption of By-laws for the regulation of the corporation was next considered. The secretary presented to the meeting a form of By-laws which were duly considered and discussed. On motion duly made, seconded and unanimously carried, the following resolutions were adopted:

WHEREAS, the shareholders of this corporation have not as yet adopted any By-laws for the regulation of its affairs; and

WHEREAS, there has been presented to this meeting a form of By-laws for the regulation of the affairs of this corporation; and

WHEREAS, it is deemed to be to the best interests of this corporation and its shareholders that said By-laws be adopted by this Board of Directors as and for the By-laws of this corporation;

> NOW, THEREFORE, BE IT RESOLVED, that the By-laws presented to this meeting and discussed hereat be and the same hereby are adopted as and for the By-laws of this corporation.
>
> RESOLVED FURTHER, that the secretary of this corporation be and he hereby is authorized and directed to execute a certificate of the adoption of said By-laws and to insert said By-laws as so certified in the Book of Minutes of this corporation and to see that a copy of said By-laws, similarly certified, is kept at the principal office for the transaction of business of this corporation, in accordance with Section 502 of the California Corporations Code.

ELECTION OF OFFICERS

The meeting proceeded to the election of a President, a Vice-President, a Secretary and a Treasurer. The following were duly nominated and elected to the offices indicated after their names:

MISCELLANEOUS BUSINESS

RESOLVED, that the officers of this corporation be, and they hereby are authorized and directed to enter into the Ancillary Service Agreement with Perris Valley Scientific, a California corporation, substantially in the form as that appended hereto as Exhibit "A".

RESOLVED, FURTHER, that it is deemed to be in the best interest of this corporation to retain the services of Medical Environments, Inc., a California corporation, to act as Administrator of the Community Hospital of the Valleys, and, accordingly, the officers of this corporation be, and they hereby are, authorized and directed to enter into a management and consulting agreement with Medical Environments, Inc., substantially in the form as that appended hereto as Exhibit "B".

RESOLVED, FURTHER, that the President, Vice President, and the Secretary or Assistant Secretary of this corporation be, and they hereby are authorized and directed to apply to the Internal Revenue Service and California Franchise Tax Board for recognition of an income tax exemption, and further to seek a determination that the contributions made to this corporation shall be deductible for income tax purposes.

RESOLVED, FURTHER, that the officers of this corporation be, and they hereby are, authorized and directed to borrow from Perris Valley Scientific, a California corporation, the sum of Two Hundred Ten Thousand Dollars ($210,000.00), and to execute a promissory note in said amount providing repayment of said sum in monthly installments of Four Thousand Four Hundred Ninety Dollars ($4,490.00), including principal and interest at the rate of nine per cent (9%) per annum, commencing May 1, 1977, until paid. Further, said note shall be secured by a Security Agreement substantially in the form as that appended hereto as Exhibit "C", and at the request of Perris Valley Scientific, the officers of this corporation shall execute a California Financing Statement, Form UCC-1, in accordance with the provisions of said Security Agreement.

RESOLVED, FURTHER, that the officers of this corporation be, and they hereby are authorized and directed to apply with the California State Department of Health for a hospital license for the facility located at 2224 North Ruby Drive, Perris, California, and, in this regard, Medical Environments, Inc., is hereby appointed as the authorized agent to deal on behalf of this corporation with the said Department of Health as well as utilities and any other person, firm or entity in connection with the licensing of the hospital.

RESOLVED, FURTHER, that the officers of this corporation be, and they hereby are authorized and directed to execute all documents and to take such action as they may deem necessary or advisable in order to carry out and perform the purposes of these resolutions.

ADJOURNMENT

There being no further business to come before the meeting, upon motion duly made, seconded and unanimously carried, the meeting was adjourned.

STEPHEN K. MILLER
Temporary Chairman

STEPHEN K. MILLER
President and Chairman

ATTEST:

SHARON BRUNNER
Temporary Secretary

LUDLOW B. CREARY, M.D.
Secretary

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EXHIBIT I

Mr. Kenneth Hahn
Community Hospital of the Valleys
2224 Ruby Drive
Perris, California 92370

Dear Mr. Hahn:

This will confirm our discussions and agreements made with respect to the ownership of the land, buildings, and equipment which are currently leased by Community Hospital of the Valleys, a California Non-Profit Corporation, from Perris Valley Community Hospital, Ltd., a California Limited Partnership and Tatkin Investment Company, a California Corporation, the lessors of said land, buildings and equipment to Community Hospital of the Valleys. As you are aware, Perris Valley Scientific, Ltd., a Limited Partnership, has an option to acquire the hospital land and building (but not the medical building or equipment, although discussions have been had with Mr. Allen G. Tatkin, the principal in all lessor entities, that he would be amenable to sell the medical building and equipment), which option is exercisable on December 31, 1981. As you are further aware, the existing lease in favor of Community Hospital of the Valleys, a Non-Profit Corporation, expires on December 31, 1981. PVS is unclear at this time as to whether at the expiration of the existing lease it will renew the lease with Community Hospital of the Valleys, operate the hospital itself, lease to another entity, or sell the hospital as a package. PVS has made commitments to Glen-Tec Respiratory Service, Universal Nuclear, Inc., Hoye-Boatwright, Inc., and Community Hospital of the Valleys Pharmacy, that it will honor the existing Ancillary Agreements between Community Hospital of the Valleys and them so long as PVS operates or controls the operating entity, but which obligation shall expire on December 31, 1990 if the hospital has not been leased to an independent operating entity or has been sold prior to that time.

You are currently a consultant to Community Hospital of the Valleys, rendering management services on its behalf, which services are in the opinion of PVS desirable and in fact necessary for the operation of that entity. We have agreed with you that at the expiration of the existing lease with

Community Hospital of the Valleys, we shall utilize our best efforts to insure that you continue to provide management on a contract basis for PVS if it decides to operate said hospital itself, or for Community Hospital of the Valleys, a Non-Profit Corporation, or any other entity owned or controlled by PVS, provided that you shall agree to render said services on behalf of any such entity, and further provided that you shall continue to render the services in a competent manner such as you are rendering at the present time.

On these same provisos, PVS agrees further as follows:

1. That you shall be entitled to a limited partnership interest in Perris Valley Scientific, Ltd., equal to [redacted] percent of the profits and losses of PVS, Ltd., in the operation itself or leasing to others of said hospital, said profits and losses to be determined in accordance with generally accepted and consistently applied accounting principles. You understand that Perris Valley Scientific, a California Corporation, the general partner of Perris Valley Scientific, Ltd., is the holder of certain Notes from Community Hospital of the Valleys, and in turn is Maker of certain Notes to PVS owners and providers. At the time the Agreement Terminating Master Ancillary Agreement and Modifying Promissory Notes is executed by PVS and Community Hospital of the Valleys, the sole asset of the limited partnership shall be the option to purchase the land and building. You understand that your interest in the profits and losses of the partnership shall relate to the equity interest in the option, and ultimately the ownership of the land and buildings, and shall specifically not include any interest in the Notes payable to PVS as corporation.

2. In addition to the above, you shall be entitled to purchase from Perris Valley Scientific, Ltd., an additional limited partnership interest equal to five (5%) percent of the profits and losses thereof, between the date hereof and December 31, 1980 for a total purchase price of [redacted] which amount must be paid in cash. If you elect to purchase the additional limited partnership interest from and after January 1, 1981, the purchase price therefor shall be based upon the fair market value of the hospital land, buildings and equipment, including the medical building, as we shall agree or as shall be determined by MAI appraisal (the cost of which shall be yours alone, and the appraiser to be selected by mutual consent) which amount shall be reduced by the sum of $1,500,000.00 or such lower sum as shall be necessary to acquire all of the remaining rights to the land, buildings and equipment from Mr. Tatkin and/or his entities, or the amount of any mortgages, deeds of trust or

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other encumbrances thereon if PVS-partnership has already acquired such assets from Mr. Tatkin or his entities.

3. You further understand that the five (5%) percent limited partnership interest in PVS-Partnership referred to in paragraph 1 above shall be terminable if you should cease rendering management-consulting services to or for the benefit of Community Hospital of the Valleys or PVS or its controlled entity. That is, this five (5%) percent limited partnership interest is intended to be additional consideration to you for the services you agree to provide for the operating entity. Of course, should PVS-Partnership lease or sell the hospital to an independent third party, this five (5%) percent limited partnership interest shall remain in full force and effect provided that you agree to provide whatever necessary services shall be necessary so as to monitor the operating entity to protect the limited partnership's interest. Upon the sale of the hospital, you understand that your five (5%) percent limited partnership interest (or ten percent limited partnership interest if you elect to purchase the additional five percent limited partnership interest provided in paragraph 2 above) shall entitle you to your respective percentage of the net profit realized upon said sale, which shall be defined as the excess of the purchase price received upon such sale over the cost of the limited partnership to acquire the assets, or the amount of any encumbrances which were incurred upon a prior purchase of said assets prior to the sale of the third party, unless further the amount owed and guaranteed to providers for services rendered to Community Hospital of the Valleys prior to August 1, 1980. Attached hereto as Exhibit "A" and incorporated herein by this reference is a proposed pay back upon the sale of the hospital at the current time assuming a sale at $3,000,000 and the cost to acquire the assets of $1,500,000. By adding the amounts of columns one and three, respectively, of this proposal, it would indicate the total equity portion of the limited partnership. Column two reflects the amount of payments owing and guaranteed to providers for services rendered prior to August 1, 1980. Accordingly, a five (5%) percent limited partnership interest would be valued at five (5%) percent of the sums of column one ($210,000) and column three ($696,000) or $906,763, and is therefore computed to be ~~[illegible],338.15~~. The additional $4,661.85 you must pay in order to purchase an additional five (5%) percent limited partnership interest is intended to create a small portion of risk on your part, and further an incentive to maintain the hospital for maximum long-term growth.

You are aware that the knowledge of the existence of this arrangement by any fiscal reimbursement intermediary or agency to take the position that you are a "related party" since you have an equity interest in PVS, Ltd. and will also be providing services to Community Hospital of the Valleys, and, accordingly, said agency may disallow a portion, or all, of the management consulting fee paid to you by the hospital. The effect of this would be to deplete further the assets of Community Hospital of the Valleys, which in turn would affect the ability of that entity to abide by its obligations owing to PVS-Corporation on the various Promissory Notes. For that reason, you agree that no document specifically providing for your partnership interest in Perris Valley Scientific, Ltd., will be prepared, and that your interest will be held in trust for you by the limited partnership and the other limited partners thereof. At such time that PVS, Ltd. has received an opinion of counsel indicating the transfer of said partnership interest will in no manner effect the reimbursement by Medi-Cal, Medi-Care or other agencies, such equity interest will be issued to you.

If the foregoing correctly reflects our understanding, kindly sign both tht original and a copy of this letter where indicated, and return both copies to me without having made any copies thereof for your files. I will thereupon deliver one of these copies to an attorney selected by you, together with a covering letter in the form as attached hereto whereby your attorney will agree to act as escrow holder for said letter and to divulge its existence and utilize its provisions if, and only if, circumstances have arisen that would entitle you to compensation hereunder, and that we have at that time a dispute between us that we have not been able to resolve. Prior to that time, however, you hereby agree that you will divulge to no person, firm or entity the existence of this letter, and further that in the event PVS discovers that you have breached this agreement, and of the terms and provisions of this letter shall be null and void, and of no force or effect whatsoever.

Very truly yours,

PERRIS VALLEY SCIENTIFIC, A California
Limited Partnership

BY: PERRIS VALLEY SCIENTIFIC, A
California Corporation

BY:____________________________
ROBERT SHMAEFF, President

BY:____________________________
MYRTIS MOYE, Secretary

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PROPOSED PAY OUT FOR HOSPITAL SALE INCLUDING RECEIVABLES FROM JANUARY 1, 1980 THROUGH JULY 31, 1980

ASSUMPTIONS:

1. First monies used to pay back initial investment.
2. Payables to providers discounted by 50%.
3. Balance disbursed pro rata to equity holders.
4. Hospital sold for $3,000,000.00.
5. Cost to acquire hospital $1,500,000.00.

NAME	NUMBER ONE	NUMBER TWO	NUMBER THREE	TOTAL	PERCENTAGE
MILLER	$ 25,000	0	$ 82,948.00	$107,948	7.20%
M & C	25,000	0	82,948.00	107,948	7.20%
CONLEY	30,000	$ 268,624	99,538.00	398,162	26.54%
SHMAEFF	60,000	137,481	199,075.00	396,566	26.44%
BOATWRIGHT & MOYE	70,000	187,132	232,254.00	489,386	32.63%
TOTALS:	$ 210,000	$ 593,237	$ 696,763.00	$1,500,000	100.00%
	A	B	C	D	

A + B + C = total 1.5 MILLION

A + C = EQUITY 906.000

B 593.237 PVS LIABILITY

50% 296,000

50% already

77-78 [illegible]

D − (A + B) = C